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Using Art Therapy to Understand the Experience of African-American Girls With Childhood Obesity

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USING ART THERAPY TO UNDERSTAND THE EXPERIENCE OF
AFRICAN-AMERICAN GIRLS WITH CHILDHOOD OBESITY

A DISSERTATION

(submitted by)

ELVA WAYNETTE ANDERSON

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

LESLEY UNIVERSITY
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Lesley University
Graduate School of Arts & Social Sciences
Ph.D. in Expressive Therapies Program

DISSERTATION APPROVAL FORM

Student's Name: _____ Elva Waynette Anderson _____

Dissertation Title: USING ART THERAPY TO UNDERSTAND THE EXPERIENCE
OF AFRICAN-AMERICAN GIRLS WITH CHILDHOOD OBESITY

Approvals

In the judgment of the following signatories, this Dissertation meets the academic standards that have been established for the Doctor of Philosophy degree.

Dissertation Committee Chairperson: Michelle Finner 3/20/15
(date)

Internal Committee Member: Rosemary C. Cunniff 3/20/15
(date)

External Committee Member: Steph H. H. H. H. 3/20/15
(date)

Director of the Ph.D. Program/External Examiner: [Signature] 4-9-15
(date)

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate School of Arts and Social Sciences.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Michelle Finner 3/20/15
Dissertation Director

I hereby accept the recommendation of the Dissertation Committee and its Chairperson

[Signature]
Dean, Graduate School of Arts and Social Sciences

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SIGNED: *Elva W. Anderson*

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ABSTRACT

The growing epidemic of childhood obesity in the United States disproportionately affects African-American children. Traditional use of behavior modification and nutrition counseling in weight reduction programs for obese children have not been successful in overcoming the social, cultural, and psychological barriers to effective weight control. Although art therapy can provide important insights into the life challenges faced by obese children, there has been little research on the use of art therapy to increase understanding of the lived experiences of African-American girls living with obesity. By understanding their perspective, it will assist in developing theory as a means to create better interventions.

A total of 10 African-American girls, age 12-17, who were enrolled in a weight management program, participated in this phenomenological study. In each of three 45-60 minute sessions, the girls were given a directive to draw a self-portrait about their experience of home, school, and self-perception. The girls were encouraged to talk about their experience in the selected environment. After the completion of each drawing, the researcher asked each girl what she saw when looking at each drawing.

Data analysis revealed that all girls suffered negative consequences from their weight such as bullying and teasing at home and school, social isolation, and psychosocial issues such as depression and low self-esteem.

The girls reported the art therapy sessions provided a safe holding environment where they were able to share their lived experiences as seen in the visual imagery that emerged from the artwork. When the girls were asked how they felt about the art therapy,

all of the girls responded positively and said the art was very beneficial in helping them share their stories about living with obesity.

The study results suggest art therapy can provide the multidisciplinary medical team that care for children with a non-pharmacological, adjunctive modality that provides access to the children's real-life experience of obesity. This access to lived experience can provide critical insights into factors that may inhibit the children's ability to adhere to a weight loss regimen, and need for on-going mental health assessment and treatment.

Keywords: Obesity, art therapy, African-American female adolescents

CHAPTER 1

Introduction

According to the American Academy of Pediatric Obesity, childhood obesity has risen to epidemic proportions and is now one of the most urgent public health problems in the U. S. (Centers for Disease Control and Prevention [CDC], 2011a; Flegal, Tabak, & Ogden, 2006; Hassink, 2007; Ogden, Carroll, Kit, & Flegal, 2014). In 2011, the CDC reported that 32 % of all American children and adolescents, aged 2-19, were either overweight or obese. The 12.5 million American children who are obese deal with a myriad of related medical problems such as high cholesterol levels, hypertension, and Type II diabetes, which has doubled in children with obesity during the past 25 years.

Concern for the health of teenagers with obesity and the limited effectiveness of behavioral approaches in severe obesity has also led to a dramatic increase in the number of American teenagers who each year undergo extreme and often dangerous surgical procedures to lose weight such as gastric bypass and gastric banding (Tsai, Inge, & Burd, 2007). This dramatic increase in pediatric diabetes led the CDC in (2011a) to classify childhood obesity as a national epidemic.

Problem Statement

In addition to offering sound nutritional advice and rewards for behavior modification, successful weight reduction programs must help children with obesity address the underlying psychosocial factors that result in poor eating choices and weight gain (Kronenfeld, 2002). Associated lifestyle choices and personal habits are just as important to address as medical treatment. Some authorities feel psychological and

social problems are both contributing factors and consequences of obesity in children (Gray, Kahhan, & Janicke, 2009; Puder & Munsch, 2010; Summerfield, 1990).

Since 2000, the incorporation of best practices in behavior modification into weight reduction programs for children with obesity has not been sufficient to overcome the multiple barriers to effective weight control in American children. Research has suggested many parents of obese children rely on unrealistic objectives for themselves and their children relative to controlling or losing weight (Hart, Bishop, & Truby, 2003). From a developmental perspective, children may be ill-equipped to intellectualize their individual feelings or thinking processes about such negative behaviors as overeating or eating unhealthy food. According to Messina, Saba, Vollono, Leclercq, and Piccinelli (2004), adolescents can be quite uncertain in their attitudes and beliefs about eating an unhealthy diet. Other reports have found that many adults and children view traditional education programs and counseling as intrusive, and that resentment against the intrusion results in failure to lose weight (Hart et al., 2003). More recent reports suggest most contemporary weight reduction programs for children with obesity fail because they are based on rote learning which does not include age-appropriate strategies and rewards for the children (Olstad & McCargar, 2009).

Ashcraft (2012) identified additional barriers to the successful treatment of obesity in adolescents. Since different cultural groups may perceive their weight status differently from health care practitioners, Anderson (1983) emphasized the critical need for health care practitioners to be aware of different cultural ideals as they seek to understand the sociocultural factors related to health behaviors. For example, research has shown that African Americans have a greater tolerance for higher weight and less

pressure for thinness (Caprio et al., 2008; Plybon et al., 2009); larger girth is often viewed positively by this cultural group as a sign of social prominence, success, and good health (Plybon et al., 2009).

Anderson (1983) asserted that health care practitioners who fail to engage adolescents on a personal level diminish the potential for the adolescents' successful weight loss. To realize successful outcomes for these adolescents, health care providers must understand and incorporate adolescents' understanding, knowledge, values, and experiences related to obesity in treatment planning. These experiences might include life experiences, social relationships, societal influences, structural forces that are known to contribute to self-perception, and methods that peers use to interpret information about each other (Sorensen et al., 2007). Art therapy is a cost-effective avenue for accessing the personal perspectives and beliefs of obese adolescents.

Purpose

This study was designed to investigate the use of art therapy as an adjunctive therapeutic modality for understanding the life experience of African-American girls with childhood obesity.

Research Questions

The primary research question is: What is the life experience of African-American girls with childhood obesity? Two related subquestions were incorporated into the study: How can art therapy help public health professionals better understand the experience of childhood obesity in African-American girls? How can this understanding be used in weight reduction programs designed for obese children?

Significance of the Study

In addition to the physical consequences of obesity, children with obesity are also at risk for psychosocial problems such as high levels of stress, low self-esteem, depression, teasing, and peer victimization (Dockray, Susman, & Dorn, 2009; Gray et al., 2009; Gundersen, Mahatmya, Garasky, & Lohman, 2010; Hayden-Wade et al., 2005; Ludwig, 2007; Rosal, Turner-Schikler, & Yurt, 1998; Sanderson, Patton, McKercher, Dwyer, & Venn, 2011). Children are known to respond differently than adults to obesity (Daniels, 2006), and to the emotional stress associated with it (Levitan & Davis, 2010).

The obesity problem and the rise in Type II diabetes in American children are believed to be the result of multiple environmental and socioeconomic factors that affect food choices and body weight (Eisenmann et al., 2008). These include the increased availability of highly processed, inexpensive, sweetened foods and an increasingly sedentary lifestyle characterized by a lack of exercise at both school and home (Collison, Zaidi, Subhani, Al-Rubeaan, & Shoukri, 2010). Children from low-income families are especially at risk for obesity because low-income families often buy food from local venues and fast food restaurants where inexpensive high-fat, high-sugar foods are readily available (McCarthy, 2004). Cress et al. (2005) expressed the frustration that although adults consciously realize that diet and improved exercise habits are critical for the health and wellbeing of their families, they still fail to make the appropriate adjustments to their family's eating and workout habits.

For more than 20 years, standard treatment modalities for children with obesity have included behavior modification strategies that integrate lifestyle choices in tandem with physical education and more healthy diet options in their school dining areas

(Simons-Morton, Parcel, Baranowski, Forthofer, & O'Hara, 1991). In addition to nutrition planning and “determining appropriate motivational factors sufficient to elicit change, goal setting, and reward structures” (Devahl, King, & Williamson, 2005, p. 295), behavior modification must consider (a) the social support around an individual, (a) the individual's self-efficacy, (c) the selection of active choices, (d) tools such as health contracts, (e) children's perceived safety, (f) regular performance information and feedback, and (g) positive reinforcement (Cress et al., 2005, p. 6-7).

Art therapy has been used successfully in a variety of settings with children with psychosocial, emotional, and mental health issues that include obesity (Anzules, Haenni, & Golay, 2007). The goal is to use the creative process of self-expression and reflection to explore feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem (American Art Therapy Association, 2011). Children are more likely to internalize their feelings than adults, are less likely than adults to express distressing feelings, and may vary in their reactions depending on the context of the illness (Anzules et al., 2007; Gundersen et al., 2010).

A fundamental principle of art therapy is that art assists in the expression of feelings and thoughts that would not otherwise be expressed (Sahley, 2006). In public health, the reflection on and expression of such thoughts and feelings can help health care practitioners understand what it means for a person living with a medical diagnosis or to *be* a person with anorexia, a person with diabetes, or in the proposed study, an African-American girl living with obesity. As suggested by the philosopher Heidegger (1962), the exploration of “*being*” is the exploration of how humans understand and exist in the

world. Spiegelberg suggested in 1982 that this was “the world of lived experience” (p. 144).

One promising type of art therapy involves drawing self-portraits, which have been used for several decades as a common art therapy technique (Malchiodi, 1998). Researchers have noted that self-portraits have been used as reflective tools in many different therapeutic settings with diverse populations such as persons with Alzheimer’s, addictions, and obesity (Betts, 2003; Cockle, 1994; Gair, 1975; Glaister, 1996; Hanes, 2007). Alter-Muri (2007) noted that “Self-portraits can be used as a tool to assist the artist to step back from an experience and to reflect on that experience” (p. 331).

In 1998, Rosal et al. (1998) recommended the integration of art therapy into childhood obesity programs. In one study with African-American girls with obesity, art therapy provided unique access to the girls’ self-perception, which is known as a major determinant in the quality of decisions made by adolescents (Loughnan et al., 2010).

The current study can make a significant contribution to public health efforts that have been unsuccessful in decreasing obesity in African-American girls. The increase of obesity has been greater among African-American females (Baskin, Ahluwalia, & Resnicow, 2001). This contribution will enhance the art therapy profession by demonstrating the utility of art therapy in understanding the life experience of African-American girls with childhood obesity, and providing public health professionals with new insights that can be used to improve the efficacy of treatment for children with obesity.

Summary of Methodology

The researcher conducted a phenomenological study in which the data analysis uncovered units of meaning that described the phenomenon under study (Creswell, 2003; Denzin, 1989). The research was guided by qualitative methods as reflected in the primary question: What is the life experience of African-American girls with childhood obesity?

The researcher attempted to understand the essence or meaning of a human experience; discover the qualitative aspects of the phenomenon; engage self as an active participant in the inquiry; focus on the essence or meaning of the phenomenon, not causal or predictive relationships; and to illuminate through description, illustrations, metaphors, dialogue, or other creative means (Moustakas, 1990). The purpose, Denzin (1989) suggested is to capture the voices, emotions, and life experiences that alter and shape the meaning individuals give to themselves and their life experience. In this study, African-American girls with obesity offered illumination about their experiences in three contexts—home, school, and self-perception which were accessed through interviews and art therapy. As suggested by Lincoln and Guba (1985), the context provides an understanding of a person situated in time and in their natural setting. In this study understanding the girls' day-to-day experience with childhood obesity at their age and stage of life and the meaning the girls ascribe to that experience is a critical first step in assisting the multi-disciplinary team who provide counseling for these girls.

The researcher conducted a series of three 45-60-minute face-to-face interviews with the 10 girls in the study. Interview questions about the experience of being a girl with obesity included questions of past-present-future types: behavior and experience,

feelings, opinion and values, knowledge, and sensory and demographic factors (Patton, 1987). These questions were adapted as the interviews continued and new areas of discovery emerged. As suggested by Creswell (2003), “The questions may change and be refined as the researcher learns what to ask” (p. 181).

The girls in the study created a series of drawings that reflected their home, school, and self-perception. After each girl completed each drawing, the researcher asked them to describe the drawings and how they felt about the artwork. Thick description (Geertz, 1973) was gathered during the discussion of the girls’ art that reflected their self-perceptions of being a girl with obesity, and their perception of what it is like to be an obese girl at home and at school.

Limitations

The scope of the study was limited to African-American girls living with obesity, ages 12-17, who are currently enrolled in a weight management program in Washington, D.C. The study was a phenomenological study designed to reveal and understand the girls’ lived experience with obesity through their voices and artifacts, as opposed to the researcher’s perspective. The study’s findings are subject to the general limitations of generalizability within field research (Stake, 1995), and are not generalizable to other populations of American adolescents.

Delimitations

The study was limited in duration, and was not a full-scale ethnographic study that might include observation of the girls’ home and school environments or the perspectives of the girls’ families and friends. The study was not designed to identify causal or predictive factors relationships involved in the girls’ struggle with childhood

obesity, or to evaluate the efficacy of the counseling the girls received in the weight reduction program.

CHAPTER 2

Literature Review

Obesity is characterized by an “excessively high amount of body fat in relation to lean body mass or as BMI for age greater than the 95th percentile” (Anderson, 1983; Fletcher, Cooper, Helms, Northington, & Winters, 2009, p. 45; Hassink, 2007; Sanderson et al., 2011; Summerfield, 2000). According to the American Academy of Pediatrics, childhood obesity has risen to epidemic proportions and is one of the most urgent health issues of children and adolescents in the United States (Anderson & Butcher, 2006; Cunningham, Kramer, & Narayan, 2014; Daniels, 2006; Flegal et al., 2006; Hassink, 2007). The prevalence of childhood obesity has been progressively increasing, with approximately 12.5 million children between the ages of 2-19 classified as obese. With data from the National Health and Nutrition Examination Survey (NHANES) and a cross-sectional representative sample of 4,111 American children, the overall prevalence of obesity in this population has been estimated at 31.8% (Ogden, Carroll, & Flegal, 2008). The most recent analysis of NHANES (Skinner & Skelton, 2014) found that there is an upward trend in severe childhood obesity and that all classes of obesity in American children, ages 2-19, have increased over the last 14 years.

Childhood obesity is the result of genetic, psychological, nutritional, familial, and physiological factors (Kidsource Online, 2013). Pratt and Greer (2012) noted that, in addition to medical comorbidities, childhood obesity is associated with psychosocial comorbidities such as depression, poor self-image, and poor self-esteem.

The ideal time to prevent and treat childhood obesity is early childhood (Monasta et al., 2010; Wofford, 2008). Health care interventions such as nutrition education,

psychological counseling, physical activity, bariatric surgery, pharmacotherapy, and low-cost adjunctive tools such as art therapy encourage healthy eating and healthy lifestyles.

Art therapy has the potential to be a useful adjunct to the primary treatment for childhood obesity because it has been used successfully with children who are experiencing emotional, psychosocial, and mental health issues (American Art Therapy Association, 2011). When used in a weight management program for girls with obesity, art therapy may serve as a bridge between the rigid divisions of labor and professional siloes that exist in and inhibit innovation within the health care system (National Academy of Engineering and Institute of Medicine, 2005). Thus, the literature on the prevalence and multimodal treatment of childhood obesity and the use of art therapy with obese children are central to this literature review.

The ProQuest/ABI Inform, Medline (PubMed/EBSCO), PsycINFO 1887-present, SAGE Journals Online, CINAHL, ERIC (EBSCO) databases and the Web of Science database (Science Citation Index, the Social Sciences Index, and the Arts and Humanities Index) were used to access relevant literature. A search within each database was conducted with the terms childhood obesity, obesity treatment, cultural determinants of body image, art therapy in public health, and art therapy in the treatment of obesity. Through the use of books as well as peer-reviewed theoretical and empirical articles, this review incorporates, presents, and critiques works from public health and art therapy that support the research agenda. This chapter includes an overview of the prevalence, etiology, and treatment of childhood obesity; art therapy and its use in public health; and the use of art therapy as tool in the treatment of obese children.

Childhood Obesity

Obesity rates have more than tripled in the past 30 years (Ogden, Carroll, & Flegal, 2008). Some estimates suggest that 32% of American children and adolescents are either overweight or obese (Hassink, 2007; Ogden et al., 2008). Fletcher et al. (2009) noted an estimated 12 million American children between the ages of 2-19 were overweight, with African-American children comprising 20% of this group.

Overview

Two recent reports have advanced our understanding of childhood obesity in the U.S. A recent claim by the CDC (Ogden, Carroll, Kit, & Flegal, 2014) that heralded a recent decline in obesity among American preschool children aged 2-5 years has been refuted. Skinner and Shelton (2014), who analyzed NHANES data from 1999-2012, found that childhood obesity, particularly severe obesity, overall has actually increased during the last 14 years.

In their analysis of data from the Early Childhood Longitudinal Study, Cunningham, et al. (2014) found that overweight 5-year-olds were four times as likely as normal-weight children to become obese. In this research ($N=7,738$), half of the children who became obese between 5 and 14 years of age had been overweight at baseline. According to the researchers, this finding indicates that a child's future weight (termed "weight fate") may be decided by age five (p. 404), and that efforts to teach good health practices and prevent obesity should occur earlier in childhood than previously thought. These findings confirmed previous studies (Wang & Lobstein, 2006) in which overweight and obese children were found to be more likely to become overweight or obese adults than slim children.

Flanckbaum, Flanckbaum, and Manfred (2001) stated that although the “exact cause of obesity remains unknown” (p. 3), the complex etiologies of obesity include medical, physical, genetic, and emotional determinants as well as interpersonal factors (Daniels, 2006; Hassink, 2007; Hayden-Wade et al., 2005; Hill & Trowbridge, 1998; Puder & Munsch, 2010; Rosal et al., 1998). The obesity problem is further complicated by environmental and socioeconomic factors that affect food availability; food choices that include highly processed, inexpensive, sweetened foods; and lack of exercise (Collison et al. 2010, Eisenmann et al., 2008). This is especially true for children from low-income families (McCarthy, 2004).

Childhood obesity is associated with numerous adverse health effects (CDC, 2011b). Complications such as hypertension, increased risk of coronary heart disease, high cholesterol levels, Type II diabetes, and psychological and psychosocial concerns such as poor self-esteem, impulsivity, anger, mood disorders, attention-deficit hyperactivity disorder, anxiety, depression, social isolation, distorted body image, eating disorders, peer victimization (i.e. bullying and teasing), and discrimination are associated with childhood obesity (Anzules et al., 2007; CDC, 2011b; Daniels, 2006; Dockray et al., 2009; Gray et al., 2009; Gundersen et al., 2010; Haines Neumark-Sztainer, Hannan, & Robinson-O’Brien, 2008; Hassink, 2007; Hayden-Wade et al., 2005; Ludwig, 2007; Puder & Munsch, 2010; Rosal et al., 1998; Sahley, 2006; Sanderson et al., 2011; Spear et al., 2007; Summerfield, 1990). As noted by Goodman and Whitaker (2002), depression has been associated with an increased BMI in adolescents, even after controlling for socioeconomic status. The medical effects associated with the epidemic of childhood

obesity may result in the first generation of American children and adolescents who live a shorter life span than their parents (Olshansky et al., 2005).

The World Health Organization (WHO, 2013) defined health inequities as “avoidable inequalities in health between groups of people” (p. 1). Racial and ethnic inequities exist in the prevalence of childhood obesity. According to the CDC (2011c), health disparities exist because of social conditions such as poor access to health care, poverty, educational inequities, and unequal distribution of resources, and the effects of long term racism in the U.S.

The ethnic and racial inequities in the prevalence of childhood obesity must be addressed in interventions aimed at preventing and treating obesity. Taveras, Gillman, Kleinman, Rich-Edwards, and Rifas-Shiman (2010) examined the risk factors for obesity in African-American children ($n=355$) and Hispanic children ($n=128$) compared with White children ($n=1,343$) ages birth to four. There was a significantly increased chance of rapid weight gain for infants with an early introduction of solid food, the presence of a television in the child’s bedroom, higher intake of sugar-sweetened beverages, and higher consumption of fast foods. The authors concluded that interventions directed at changing early childhood risk factors could have a substantial impact on reducing disparities in the prevalence of childhood obesity.

The prevalence of obesity is greater in minority children and adolescents than in White children (Baskin, Ahluwalia, & Resnicow, 2001; Carcone, MacDonell, Naar-King, & Ellis, 2011; Chang & Lauderdale, 2005; Davis, Davis, Northington, Moll, & Kolar (2002); Davis, Young, Davis, & Moll, 2008; Hudson, 2008; Kumanyika & Grier, 2006; Ogden et al., 2008). In an integrative review of 28 research articles Hudson (2008) noted

the epidemic of childhood obesity disproportionately affects African-American children, ages 2-18 years, as compared to Caucasian children, which make obesity prevention essential in this population.

Freedman (2011) also reported higher rates of obesity in Mexican-Americans and African-Americans than Caucasians after controlling for differences in family income. The data from NHANES also revealed a major increase in rates for non-Hispanic Black youth, “for whom the odds of obesity were 42% greater in 2009-2010 compared with 2001-2002” (Rossen & Schoendorf, 2012, p. 700).

The prevalence of obesity increases with age, particularly in females, and is higher in economically disadvantaged groups (Brownell & O’Neil, 1993; Davis et al. 2008; Ogden et al., 2008). One-fourth of African-American females aged 6 to 19 years of age are obese (Ogden, Carroll, Curtin, McDowell, Tabak, & Flegal, (2006). Strauss and Knight (1999) noted children who lived with single mothers, those with obese mothers, those with mothers who did not complete high school, children with low family incomes, African-American children, children with nonprofessional parents, and those with lower cognitive stimulation had a significantly greater likelihood of becoming obese, which “begins to predominate in poorer females in adolescence” (p. 85). In 2011, Wang examined national data from the CDC, NHANES, and the Youth Risk Behavior Surveillance System to review age, ethnic, gender, geographic disparities, and socioeconomic status. Wang found that minority groups such as African-Americans show complex disparity patterns, in which obesity is worse in girls than boys, and obesity lasts for longer periods during life.

Psychosocial Factors

Obesity can influence psychosocial development (Wang & Lobstein, 2006).

In their study of relationships between obesity and impulsivity, poor social functioning, depression, and familial influences, Puder and Munsch (2010) noted equivocal data on the association between impulsivity and/or attention deficit hyperactive disorder (ADHD) and increased body weight; and the need for early detection of psychological factors in obese children. Other research found that overweight children had more delinquent problems and were viewed by peers as more aggressive and disruptive than normal weight children. This was attributed to poor self-esteem, anger, anxiety, and depression (Hwang et al., 2006; Zeller, Reiter-Purtill, & Ramey, 2008).

Sanderson et al. (2011) conducted a 20-year cohort study with 2,000 women and men who were first interviewed as children between 7-15 years of age and again as adults between 26-36 years of age. The researchers found that childhood obesity was associated with mood disorders in adulthood. When weight in adulthood was taken into consideration, the increased risk of mood disorder was observed only among overweight girls who were also obese in adulthood. The findings reaffirmed the importance of addressing lifestyle, personal habits, emotional issues, and body image in the medical treatment of obese children (Anzules et al., 2007; Malchiodi, 1998).

Gundersen et al. (2010) defined psychosocial stressors as external conditions or events that threaten an individual's wellbeing. Gundersen et al. analyzed 11 studies of obese children and adolescents' psychological and psychosocial stressors at the individual and household level. In their meta-analysis, the researchers found that individual conditions and events included poor mental health and engagement in risky

behaviors. Household events included poor parental mental health and marital quality, parental divorce, child abuse, domestic violence, and chronic physical health conditions of family members. The analysis found that psychosocial stressors represent a real barrier to the physical and mental capacities of individual children, and lead to a wide array of unsafe and negative health outcomes for children. The effects of stress on children and adolescents and reducing exposure to stressors should be taken into consideration when evaluating the benefits and costs of different social policies and programs (Gundersen et al., 2010).

The Gundersen et al. (2010) review concluded that policies and programs need to help obese children build their resources and learn how to cope with psychosocial stressors. Puder and Munsch's (2010) findings agreed with Gundersen et al. (2010) on the importance of assessing psychological problems during the treatment process.

In their case study research of emotions in eating behavior, Levitan and Davis (2010) addressed the use of food to modify negative mood states and food intake as an addiction. The research team found that comfort eating develops during childhood and continues into adulthood. There are emotional triggers for overeating as seen in two common phenomena: stress-related emotional eating and eating that stems from negative emotions. Levitan and Davis suggested that adolescence is an appropriate stage for prevention and treatment of obesity and that attachment theory should be explored as a way to understand stress and emotional eating. By acknowledging the behavioral and developmental stage of an overweight or obese child, a therapist can diagnose and treat the psychological distress that may prompt emotional stress and overeating (Puder & Munsch, 2010).

Social Stigma of Body Fat

Obesity in children has psychological and psychosocial effects. The social stigma “point to a culture in which the well-trained body is highly valued, and obesity devalued” (Natvik, Gjengeld, & Raheem, 2013). Obese individuals suffer from negative stereotyping in which they are perceived as greedy, lazy, and lacking self-control (Guthman, 2007; Hudson, 2008; Natvik et al., 2013; Schuster & Tealer, 2009). Gard and Wright (2005) suggested that the popular narrative about the obesity epidemic is portrayed as a society-wide contagion of sloth, gluttony, and decline.

The stigma from being obese exerts a negative influence on the emotional and psychological health of obese children. These children suffer from psychosocial and psychological problems related to their weight such as negative body image, eating disorders, low self-esteem, mood disturbances, emotional distress, and depressive symptoms (Goldfield et al., 2010).

African-American Cultural Perspectives

In their analysis of data from the Centers of Disease Control, Cowart et al. (2010) found that 38% of African Americans are obese, and 70% are overweight. By gender, 49% of African- American women are obese and 77% are overweight, while 28% of African-American men are obese and 63% are overweight. African-American women have the highest incidence of obesity when compared to women of any other ethnicity and race (Hudson, 2008).

African-American adolescents are disproportionately affected by the obesity epidemic (Carcone, MacDonell, Naar-King, & Ellis, 2011; Hedley et al., 2004; Hudson, 2008; Ogden, Flegal, Carroll, & Johnson, 2002). In an integrative review of 28 research

articles Hudson (2008) noted the epidemic of childhood obesity disproportionately affects African-American children, ages 2-18 years, as compared to Caucasian children, which make obesity prevention essential in this population. The prevalence of obesity increases with age, particularly in females, and is higher in economically disadvantaged groups (Brownell & O'Neil, 1993; Davis et al., 2008; Ogden et al., 2008). Strauss and Knight (1999) noted children who lived with single mothers, those with obese mothers, those with mothers who did not complete high school, children with low family incomes, African-American children, children with nonprofessional parents, and those with lower cognitive stimulation had a significantly greater likelihood of becoming obese, which “begins to predominate in poorer females in adolescence” (p. 85). Davis’ (2004) results reported African-American parents were uninformed of their obese child’s negative experiences which are internalized.

Kumanyika and Charleston (1992) noted that a cultural acceptance of excess weight can contribute to obesity among African Americans, and can make standard weight loss programs unsuccessful. Hudson (2008) suggested that attitudes and perceptions of obesity, physical activity, and diet “may contribute to an environment that discourages healthy weight and encourages obesity” (p. 163).

Qualitative research with surveys and quantitative research with standardized instruments that assess body image have confirmed that African Americans prefer large silhouettes (Altabe, 1998; Barroso, Peters, Johnson, Kelder, & Jefferson, 2010; Jones, Fries, & Danish, 2006; Killion, Hughes, Wendt, Pease, & Nicklas, 2006; Kronenfeld, 2002; Parnell et al., 1996; Rosal et al. 1998; Siegel, Yancey, Aneshensel, & Schuler, 1999). Other research has shown that African Americans have a greater tolerance for

higher weight and less pressure for thinness (Caprio et al., 2008; Plybon et al., 2009).

The larger girth is often viewed positively by this cultural group as a sign of social prominence, success, good health, and healthy (Kumanyika, 1993; Plybon et al., 2009).

Other studies have reported African American girls expressed less concern about being overweight and feel less pressured by society to be thin (Kemper, Sargent, Drane, Valois, & Hussey, 1994; Wilson, Sargent, & Dias, 1994). Gluck and Geliebter (2002) found that African-American adolescents reported “greater body image satisfaction and prefer larger body sizes than do other ethnic groups” (p. 224). Lawrence and Thelen (1995) reported:

African-American children may receive different messages from their parents about the ideal female figure, which can result in less concern about weight issues in young African- American children approaching puberty. They may be exposed to an increasing variety of people and become more concerned with their friends’ opinions than their mothers’. As African-American girls approach adolescence, they may become more susceptible to societal attitudes about thinness that some Caucasian children are exposed to. (p. 47)

Hudson (2008) noted “many African-Americans perceive obesity as attractive or even as healthy” (p. 148). Alleyne and LaPoint (2004), as well as Johnson and Broadnax (2003), also noted that perceptions of weight in the African-American culture present challenges to the occurrence of obesity and its health-related problems. Hudson (2008) found that African-American girls believed being overweight was normal or ideal, and that this perception encouraged them to be less physically active than non-obese girls. After reviewing the girls’ 7-day food diaries, Hudson found that 55% of the girls consumed fried and/or high-fat foods two times per day, 70% drank at least two sodas a day, and

most did not eat the recommended number of fruits and vegetables daily. Paeratakul, White, Williamson, Ryan, and Bray (2002) noted African-American women reported “less pressure to be thin, less dissatisfaction with their weight, and greater acceptance of being overweight than Caucasian women” (p. 532).

The 1999 study by Neumark-Sztainer, Story, Falkner, Beuhring, and Resnick included a sample of 9,118 adolescents who completed a classroom survey of body image and weight loss behaviors. Youth from low socioeconomic backgrounds were at greater risk for unhealthy eating than youth from high socioeconomic backgrounds. African-American and Hispanic girls were less likely than White girls to diet and exercise, and were more likely to report concerns over their body shape. Relatively high rates of unhealthy eating were reported by African-American and Hispanic boys. In another study that used BMI to assess body-size satisfaction among 215 low-income, urban, caregivers of African-American adolescents, 73% of caregivers believed that their adolescent should remain at the same weight (Mitola, Papas, Le, Fusillo, & Black, 2007).

According to communications research with low-income African-American adolescents by Grant et al. (1999), boys and girls were found to be vulnerable to messages communicated by the weight-based model of beauty and health. The adolescents were at risk for poor body image and, subsequently, depression. Grant et al. noted low-income African-American adolescents may be “less likely to receive adequate treatment and their families may lack resources to reverse the negative effects of poor choices associated with depression” (p. 310).

Burgard (2009) suggested that initiatives such as the “health at any size” movement may offer an approach that resists “stigmatized cultural ideas of fat while

promoting physical and emotional well-being” (p. 285). Cox, Zunker, Wingo, Thomas, and Ard’s (2010) findings suggested that improving physical functioning and avoiding social stigmas may be appealing to African-American women and could facilitate behavior change and weight reduction. Chen and Wang (2011) concluded that African-American adolescents may be “likely to be receptive to obesity interventions” (p. 226).

Bluestone and Tamis-LeMonda (1999) noted parental depression appeared to compromise African-American mothers’ abilities to engage in more optimal forms of parenting. Young (2004) reported that many African-American females do not easily recognize depressive symptoms due to their “strong black woman” filter. Davis et al. (2008) suggested obese African-American children “may engage more in internalizing behavioral problems” (p. 64). These findings are consistent with Davis’ (2004) focus group results, which reported African-American parents were uninformed of their obese child’s internalized negative experiences. Hudson (2008) noted some African-American parents perceived weight as genetically predetermined and outside of their realm of control.

Recent research with rural African-American families by Kronenfeld, Reba-Harrelson, Von Holle, Reyes, and Bulik (2010) reported parents in this group often rejected typically thin ideals and preferred larger body sizes, specifically as it related to their daughters.

Costs

The prevalence of obesity has more than tripled in the past 30 years (Ogden et al., 2008). This increase carries a great economic cost for obese individuals and society at large. According to Raj and Kumar (2010), obesity in the last two decades has increased

the health care costs associated with obesity-related conditions and the treatment of obesity. In the U.S., the total cost of obesity is nearly \$190 billion per year; these costs are both indirect (such as loss of work) and direct (health care services; Harvard School of Public Health, 2014).

Tsai et al. (2011) reviewed the medical costs associated with obesity in the U.S., conducted a meta-analysis of 33 U.S. studies from 1992 through 2008, and converted the results into the value of the 2008 dollar. Their findings indicated that annual obesity-related medical costs were \$1,723 higher for obese individuals compared to normal weight individuals (p. 50). In 2008, the combined U.S. cost of care for those who were overweight and/or obese was \$113.9 billion, or about 5-10% of all health care spending in 2008 (Tsai et al., 2011, p. 56). Pratt and Greer (2012) noted that obesity was “not recognized as a noted disease by private insurance, nor is it eligible for insurance coverage ... rather diseases stemming from obesity are covered” (p. 148). Heshka and Allison (2001) added that public health organizations do not use a consistent definition of obesity.

Treatment

It is important to understand and treat childhood obesity because there are adverse effects of obesity that are medical and economical as well (American Academy of Pediatrics, 2011; Gray et al., 2009; Puder & Munsch, 2010) and because treating obesity in adulthood is more difficult (Pinhas-Hamiel & Zeitler, 2005).

Raj and Kumar (2010) reported that the treatment of obesity in children and adolescents requires a:

multidisciplinary, multi-phase approach-- a holistic approach to tackle the childhood obesity epidemic with a collection of activities including empowering providers, as well as enriching and reinforcing individual awareness and skills. (p. 598).

Raj and Kumar further noted that unless this epidemic is contained, the implications of this global phenomenon will be serious on future generations and need to be perceived with vigor.

Healthy and well-balanced meals are important at any age. To prevent complications from obesity, the American Heart Association (2011) recommended that individuals reach and maintain an appropriate body weight by making small but permanent changes in eating habits rather than making a series of short-term changes that cannot be maintained. Children are known to be far more prone to the well-crafted marketing strategies designed by makers of unhealthy food products, which target them exclusively (Cawley, 2006; Ludwig, 2007). There is abundant evidence that poor diet, poor meal-planning, and negative behavioral and lifestyle issues (such as increased television viewing, lack of physical activity and exercise, lack of recreational facilities, unhealthy school meals, sleep deprivation, and unsafe parks with crime and defective equipment) all contribute to obesity (Anderson, 2006; Collison et al., 2010; Hill & Trowbridge, 1998; Puder & Munsch, 2010).

Changing the diet, improving eating habits, increasing physical activities, increasing parental involvement, and involving the community are only part of the solution to the public health crisis of childhood obesity (Haines et al., 2008; Hill & Trowbridge, 1998; Po'e, Gesell, Caples, Escarfuller & Barkin, 2010). It has been noted

that obese children tend to become obese adults, and the chances are even greater one parent is obese (Charney, Goodman, McBride, Lyon, & Pratt, 1976; Fletcher et al., 2009; Hill & Trowbridge, 1998; Hudson, 2008).

In the United States, the decreased costs of foods high in fat and sugar have been associated with increased rates of obesity. In considering economic conditions related to poor diet and lifestyle choices, Anderson (2006), Gundersen et al. (2010), Hassink (2007), and McCarthy (2004) suggested that obesity is essentially a low-income condition. Obesity rates are significantly higher among the poor, who are more likely to depend on high-fat, high-sugar foods for their meals than those in higher-income groups (Hassink, 2007; McCarthy, 2004). Limited accessibility of healthy foods, as well as financial and household instability, should be considered as fundamental factors in childhood obesity (Anderson, 2006; Cawley, 2006; Chambers, Duarte, & Yang, 2009).

Fletcher et al. (2009) addressed the need for innovative approaches that extend beyond epidemiological research when comparing the health of African-Americans and White Americans. In 2009, it was Fletcher et al. (2009) who piloted the first weight control program specifically designed for African-American children.

Wang and Lim (2012) noted that although obesity is technically preventable, it is difficult to cure. Obesity that occurs in childhood is more likely to be more severe in adulthood, when it is associated with severe weight-related health conditions (CDC, 2011b). Obesity interventions are known to be more effective when approaches and strategies are combined rather than undertaken in isolation (Anzules et al., 2007; Bresler, 1988; Gundersen et al., 2010; Po'e et al., 2010; Rosal et al., 1998; Tsiros, Sinn, Coates, Howe & Buckley, 2008). There is also recent evidence that multilevel, multisector

approaches that focus on children's environments (Foltz et al., 2012; Nader et al., 2012) and that aim to alter early life systems (Gortmaker & Taveras, 2014) are likely to be most effective in preventing obesity.

Research has also focused on the importance of addressing physical, mental, or social issues associated with childhood obesity (Hassink, 2007; Rosal et al., 1998).

Children who are educated on improving their diets and increasing the amount of physical activity require an additional motivational force to maintain lifestyle changes over time. Research has also found that behavior modification strategies can positively reinforce lifestyle changes and reduce childhood obesity if they are implemented with a physical education curriculum, healthy meals in school cafeterias, and attention to the negative mental health outcomes related to obesity (Simons-Morton, et al., 1991; Hill & Trowbridge, 2006; Po'e et al., 2010; Rosal et al., 1998).

Dietary Interventions

In their analysis of dietary patterns, Hans, Tijhuis, Lean, and Seidell (1998) noted that African Americans traditionally eat more meat, fewer vegetables, less fiber and calcium, and more high fat, high sodium, and high calorie foods. In the two-part HEALTHY-KID study ($N = 498$; $N = 450$) conducted by Wang and Lobstein in 2006 and Wang et al. in 2007, it was noted that over a 7-day period, 55% of adolescents ate high fat foods and/or fried foods two or more times a day, 70% consumed two or more sodas a day, and the majority of adolescents did not eat the daily recommended servings of vegetables and fruits.

Conventional treatment usually includes an emphasis on healthy eating patterns, elimination of fast foods, balanced healthy meals, and portion control. Stolley et al.

(2003) and Thompson et al. (2003) found parents are often not aware of their children's actual food intake, especially when children are away from home. Tsiros et al. (2008) noted "diet and physical approaches may improve obese status in the short term" (p. 9), and that obesity interventions are more effective when combined rather than used in isolation.

Physical Activity

American children have become more sedentary (Hill & Trowbridge, 1998, National Institutes of Health (NIH) , 2008). Daily, regular physical activity is suggested for the prevention of childhood obesity. To motivate obese children, it is recommended that parents and peers participate in exercise to help influence physical activity (NIH, 2008). Parental participation is also recommended in order to improve compliance (Raj & Kumar, 2010). According to McGarvey et al. (2006) and Gordon-Larsen, Nelson, Page, and Popkin (2006), many parents had a preference for sedentary activities. This is especially true in minority communities where there is a realistic concern about crime in the neighborhood (Gordon-Larsen et al., 2006; Thompson & Storey, 2003).

Behavioral Modification Techniques

As discussed by Hill and Trowbridge (1998), behavioral modification techniques may be successful and more cost-effective in modifying obese children's behavior. Tsiros et al. (2008) concluded that psychological interventions such as cognitive behavioral therapy showed promise in obesity reduction when combined with physical activity and diet approaches.

Behavioral modification programs are effective and successful when they are combined with some type of appropriate reward system, behavioral tools, and goal

setting, which all depend on the patient's compliance (Devahl et al., 2005; Penick, Filion, Fox, & Stunkard, 1971; Robinson, Smith, & Brownell, 1999).

Pharmacotherapy

There are limited data that support the efficacy and safe use of pharmacological approaches for adolescent obesity (Raj & Kumar, 2010; Tsiros et al., 2008). The drugs used with obese children, with varying results, are sibutramine, metformin, and orlistat. Sibutramine has been shown to be most effective, although the associated side effects - increased heart rate and blood pressure- have limited its use in adolescents with higher blood pressure. As noted by Tsiros et al. (2008), "long-term effects of these treatments in adolescents are unknown" (p. 10). In addition, studies of long-term treatments suggested that there is a gradual regain of weight with many patients, and that medications do not appear to be more effective than behavioral treatments for weight loss (Devlin, Yanovski, & Wilson, 2000; Wadden, Brownell, & Foster, 2002). Raj and Kumar concluded that pharmacotherapy should be "reserved as a second line of management" and considered only when there are other major health issues (p. 603).

Bariatric Surgical Intervention

According to Colquitt, Picot, Lovemann, and Clegg (2009), bariatric surgery is the most effective and lasting treatment for the severely obese compared to conventional treatments. Bariatric surgery is currently the "most rapidly growing treatment for weight loss and management of obesity-related diseases" for adults (Natvik et al., 2013, p. 1202). In a 2013 study, Natvik and colleagues interviewed eight patients who were five to seven years post-surgery. The patient described life after bariatric surgery as "living with tension, ambivalence, and reinforced attention on one's own body" (p. 1203). The tension

was related to bodily changes and altered relations such as self-perception, relationships, and rational interactions to the social world. Natvik et al. concluded that patients need more knowledge about tension, coping skills, bodily changes, and potential complications after bariatric surgery.

As suggested by Tsai et al. (2007), there has been an increase during the last decade in the number of bariatric surgeries performed on adolescents. According to Raj and Kumar (2010), adolescent candidates for bariatric surgery “should be very severely obese, have a majority of skeletal maturity, and have comorbidities related to obesity” (p. 603).

Tsiros et al.’s (2008) study indicated that outcomes in adolescents were comparable with those in adults; there was a 60% weight reduction following surgery, with the adolescents remaining at 40% above ideal body weight. After surgery, weight loss was reported, post-operative complications appeared common, and follow-up was limited (Tsiros et al., 2008). However, as noted, there is a lack of studies that explore bariatric surgical patients’ long-term postoperative experiences (Natvik et al., 2013).

Parental Involvement

Most obesity prevention/intervention programs involve helping children and their parents learn about food and eating habits and lifestyle choices such as exercise. These interventions are generally based on a repetitive curriculum of basic nutrition and standard physical activity routines, which unfortunately lack any clear motivating factors or rewards for the children who participate (Hill & Trowbridge, 2006; Olstad & McCargar, 2009).

Strauss and Knight (1999) noted that although the role of the home environment in the development of childhood obesity has been recognized, “few studies have documented the extent to which the home environment contributes to childhood obesity” (p. 85). Strauss and Knight commented that the home environment is “a critical factor in the development of childhood obesity” (p. 85). Minority children typically have the highest levels of obesity and poorest home environments with parents who may be insufficient economically and educationally (Larson, 2008) and neighborhoods with limited accessibility to healthy food options.

Hudson (2008) further suggested that low-income parents have a different understanding of obesity than mainstream health care providers. Parents are the “gatekeepers to the type and amount of food available in the home, and therefore their perception of what constitutes a healthy weight is important to consider when working with families” (p. 163). Hudson (2008) noted some parents discourage healthy eating behaviors.

According to Dietz and Gortmaker (1985), watching television has been linked to adverse health indicators such as obesity and could have unfavorable effects on health. The American Academy of Pediatrics (2001) recommended a child’s viewing time be limited to two hours per day. Crespo et al. (2001) examined NHANES 1988-1994 data that suggested among children between the ages of 8-16 who viewed television when compared to other ethnic and racial groups, 65% of African-American children viewed three or more hours of television a day, as compared to 37% of White children. Caregivers reported television to be a safer alternative to playing outside.

The Surgeon General's call to action to prevent and decrease excessive weight and obesity in children suggested to parents that setting a good example is the best help one can give a child (Gibbons, Conroy, & Bell, 1995; Golley, Perry, Magarey, & Daniels, 2007; Hassink, 2007; Lindsay, Sussner, Kim, & Gortmaker, 2006). One recommendation stated that , families should go on a family walk immediately following dinner so parents can model physical activities and healthy lifestyles as an important daily routine. As role models, parents can motivate their child to want to do more to participate in their health (Davison & Birch, 2001; Lindsay et al., 2006; Hill & Trowbridge, 2006). Pratt and Greer's (2012) work concluded that parents need to be treated as partners rather than enemies, with the accountability for childhood obesity being a shared social one to make it more possible for parents to create an improved life for their children.

Barriers to Treatment

Research has suggested many parents of obese children rely on unrealistic objectives for themselves and their children relative to controlling or losing weight (Hart et al., 2003). From a developmental perspective, children may be ill-equipped to intellectualize their individual feelings or thinking processes about such negative behaviors as overeating or eating unhealthy food. According to Messina et al. (2004), adolescents in particular can be quite uncertain in their attitudes and beliefs about eating and an unhealthy diet. Other reports have found that many adults and children view traditional education programs and counseling as intrusive, and that resentment against the intrusion results in failure to lose weight (Hart et al., 2003).

Lack of Effectiveness of Traditional Weight Loss Programs

Pinhas-Hamiel and Zeitler (2000) noted the majority of efforts to understand and treat obesity in children have proven ineffective. In 2008, Hudson recommended understanding the “motivators for, and influences to, dietary behavior and physical activity” that can be “helpful in designing interventions facilitating long-term change in African-American children” (p. 165). Hudson (2008) also suggested future research studies should examine lifestyle behaviors, causes for a decrease in activity, and “looking at strategies to incorporate lifelong physical activity behaviors” (p. 165).

Other reports suggested the structure of most contemporary weight reduction programs for obese children fail because they are based on rote learning which does not include age-appropriate rewards for the children who participate in them (Olstad & McCargar, 2009). Sargent, Pilotto, and Baur (2011) performed a review of primary care interventions ($N=12$) to treat childhood obesity and determined that interventions that were short and had low intensity (less than one contact per month) were most effective for behavior change in children with obesity.

Raj and Kumar (2010) reviewed the treatment of obesity in children and noted that successful treatment requires a multidisciplinary approach with a holistic outlook, and a long-term goal to improve the quality of life, reduce morbidity, and reduce obesity-related mortality. Heitmann, Koplan, and Lissner (2009) noted that better methodologies are needed such as measuring body composition and follow-up over an extensive time period. In addition, Anderson (1983) had asserted that health care practitioners who fail to engage adolescents on a personal level diminish the potential for the adolescents’ successful weight loss. To realize successful outcomes for these adolescents, health care

providers must understand and incorporate adolescents' understanding, knowledge, values, and experiences related to obesity in treatment planning, Anderson said. These experiences might include "lived experience" (Kapitan, 2010), life experiences, social relationships, societal influences, structural forces that are known to contribute to self-perception, and ways in which peers use and interpret information about each other (Sorensen et al., 2007).

Po'e et al. (2010) conducted a 10-month exploratory, cross-sectional, qualitative research study that included 24 program directors from Tennessee. This study identified a common obstacle faced by obesity programs—the lack of consistent participation from the target audience. Po'e et al. cited a qualitative study (Borden, Perkins, Villarruel, & Stone, 2005) that found four main reasons for lack of participation in community-based and school-based programs (a) lack of time, (b) had other interest, (c) held negative opinions of the center, or (d) constrained by parents or guardians (p. 353). Borden et al. concluded that consistent participation required high quality staff and accessible program content aimed at the specific needs of the population. However, Po'e et al. cited a different theoretical model studied at RAND Corporation. This model, set forth by McCarthy and Jinnett (2001), proposed that individual participation fell into three groups (a) those currently participating, (b) those inclined to participate, and (c) those disinclined to participate (p. 352). The research concluded that the key to increasing participation was the individual program's reputation and a supportive environment that promoted effective engagement.

Mistrust of the Health Care System

A significant barrier to the effective health education for low-income minorities is mistrust of the health care professions. This phenomenon, which has been extensively studied, has its origins in the history of racial discrimination, and the segregation and inferiority of health care for minorities in the U.S. (Bloche, 2001; Byrd & Clayton, 2002; Institute of Medicine [IOM], 2002; King & Wheeler, 2004; Sebelius, 2011) Racial and ethnic disparities in healthcare emerge from an historic context in which healthcare has been differentially allocated on the basis of social class, race, and ethnicity.

For many African Americans, the distrust of the health care system originated in the memory of the Tuskegee experiments and other abuses of Black patients by largely White health care professionals (Bloche, 2001; Breland- Noble, Bell, & Nicolas, 2006; IOM, 2002). Bloche suggested that “This legacy of distrust, which contributes to disparities in healthcare provision by discouraging African Americans from seeking or consenting to state-of-the-art medical services, is thus itself a byproduct of past racism” (p. 105). In its landmark 2003 study of racial and ethnic disparities in health care, the IOM concluded that “despite public laws and sentiment to the contrary, vestiges of this history remain and negatively the current context of healthcare delivery” (p. 123).

Limited Research

In 2009, Heitmann et al. acknowledged little is known about how to intervene effectively in the prevention of childhood obesity. Many authors have noted a major gap in the literature in understanding the impact of weight perception, obesity, and lifestyle behaviors among African- American adolescents (Alio et al., 2006; Baskin, Ahluwali, & Resnicow, 2001; Chen & Wang, 2011, Hudson, 2008).

Art Therapy

Art has been used by humans as a means of self-expression for centuries (Feder & Feder, 1998). In 2008, Camic noted the arts challenge individuals to engage in different behavioral experiences, think differently, and experience different emotions. Greene (1995) added that: “The arts offer opportunities for perceiving alternative ways of transcending and being in the world ... and to subvert our thoughtlessness and complacencies, our certainties” (p. 118). Graham (2009) explained that “Artistic expression can encourage dialogue and create profound understanding of the experiences of others” (p. 156).

As defined by Kapitan (2010), “Art therapy is defined functionally as a set of interpersonal and art-based skills used to help people come to terms with psychological, developmental, social, and behavioral stressors that impeded their health and wellbeing” (p. 30). Others define art therapy as a therapeutic intervention that uses the creative process of art and other visual media to stimulate creativity and enhance emotional and mental well-being by connecting visual imagery and healing (American Art Therapy Association, 2011; Anzules et al., 2007; Landgarten, 1981; Malchiodi, 1998). Art therapy can be viewed as a creative process that promotes positive self-awareness, self-expression, communication, emotional healing, problem-solving, and personal fulfillment; a visual path for individuals to explore their past and present experiences (Case & Dalley, 2006; Heenan, 2006; Stephenson, 2006); and a stimulant for the imaginative processes of the mind that mobilizes these processes to achieve better self-control of mental processes and healing of emotional issues (Hinz, 2009).

Art therapy also has utility in cross-cultural settings. Hall (1976), a leading theorist of the intercultural field, suggested that the tacit nature of culture gives it great power, and that extensions of culture are signs or signals of deeper meaning. Such tangible signs and signals make culture visible, and by doing so, permit a person to examine thoughts, feelings, and beliefs about nature and humanity. Art can be viewed as an extension of culture, and art therapy as the clinical pathway to improving understanding of thoughts, feelings, values, and beliefs (Hall, 1976).

Art therapy is also a nonverbal method for enhancing verbal communication through the use of color, shapes, and images (Malchiodi, 1998; Martin, 2008). As Estrella (2005) explained, “Expressive therapists use a multimodal approach -at times working with the arts in sequence, at other times using the arts simultaneously, and at still other times carefully transitioning from one art form to another within the therapeutic encounter” (p. 183). In 2008, Camic suggested that it was an important step to move beyond verbal-based therapies and to reflect upon auditory, kinesthetic, and visual elements as sources of information for both assessment and therapy.

Art Therapy in Public Health

According to Stuckey and Nobel (2010), art and health have been a focus of interest from the beginning of recorded history. Although quite distinct from conventional psychotherapy, art therapy has evolved from psychodynamic and psychoanalytic theory and shares most of its theoretical underpinnings with such approaches (Moon, 2008). In 1998, McNiff suggested it was simply a matter of time before art therapists would find “their unique place within the collective effort to advance human understanding” (p. 18). In 2004, Pratt described the expressive therapies as “a

way of restoring wholeness to a person struggling with either mind or body illness” (p. 827). Pratt predicted art therapist would “assume a greater and more important role in health care as they expand a partnership with traditional medical practice” (2004, p. 828), although four years later, Camic (2008) expressed surprise that the arts have been ignored by applied psychology as an intervention strategy. Kossak (2009) further described the great potential of art therapy:

When altered states of embodied consciousness occur through focused creative activity, a feeling of inner balance begins to emerge, mental chatter subsides, and there is a sense of full engagement in one’s ongoing experience. Focused engagement in creative activity can lead to a deeper-felt sense of connectivity to self, others, and to an expansive sense of the extended environment. (p. 15)

Kossak also noted, in expressive arts therapy, “tuning into the moment creates an opportunity for the clear articulation of creative impulses to emerge and the possibility of achieving a therapeutic attunement” (p. 17).

Over the past century, a wide range of techniques, principles, and interventions that incorporate art have been developed for the clinical assessment and treatment of mental, emotional, addictive, and behavioral problems (Camic, 2008; Case & Dalley, 2006; Curry & Kasser, 2005; DePetrillo & Winner, 2005; Hanes, 2007; Landgarten 1981). Pratt’s 2004 review described the use of the expressive therapies with different psychological and physiologic illnesses that include brain injury, dementia, depression, bereavement, pain management, sexual abuse, chronic fatigue immune dysfunction syndrome, and AIDS.

Case and Dalley (2006) reported selection of the methods used in art therapy depends on the approach of the therapist, the nature of the issue, and the needs of the client. As described below, all the reported applications of art therapy in public health across populations and disease states share a common objective, to assist patients in coping with the various physical and psychological effects of disease.

Malchiodi (1998) noted art therapy has been used in hospital settings to help patients accept the diagnosis of their illness. Borgmann (2002) studied the use of art with three women with cancer. Interviews with the women revealed the art helped them express their feelings about having cancer, which had been too difficult to put into words. Borgmann found that the women explored the meanings of past, present, and future during art therapy, they were better able to integrate cancer into their life story and give it meaning.

Guillemin's 2004 study was similar in that art therapy was used to explore how 32 middle-aged women with heart disease visualized and understood their condition. The women were asked to draw their heart disease. The women's drawings were grouped into three themes: the heart at the center, the heart in the lived body, and heart disease as a social illness. The drawings were considered to be both visual products of the women's knowledge about heart disease as well as processes of embodied knowledge production.

Monti et al. (2006) evaluated the use of mindfulness art therapy and self-portraits in a group of 111 female patients with a variety of cancer diagnoses. When compared to the control group during cancer treatment, the women in the art therapy group experienced significant decreases in symptoms of distress such as anxiety and depression (measured by the Symptoms Checklist-90- Revised) and significant improvements in

quality of life such as fewer physical and social limitations (measured by the Medical Outcomes Study Short-Form Health Survey).

Horovitz , Zarghamee, and Schulze (2008) reported stroke victims used making art as a way to reduce blood pressure, decrease stress, elevate mood, and possibly reduce their risk of future strokes. Home-based art therapy has been used successfully for patients with multiple sclerosis and for older adults with Alzheimer’s disease (Sezaki & Bloomgarden, 2000).

Portrait-Drawing in Art Therapy

One of the fundamental principles of art therapy is that art assists in the expression of feelings and thoughts that would not otherwise be expressed in words (Sahley, 2009). As noted by Betts (2003), drawing the human face has been used frequently as a measure or assessment in research. Self-portraits can be used as reflective tools in many different therapeutic settings and with diverse populations (Cockle, 1994; Glaister, 1996; Hanes, 2007). Muri (2007) stated “Self-portraits can be a tool to assist artists to step back from an experience and to reflect on that experience” (p. 331). As described below, a small number of research studies focused on the use of portrait drawing in therapeutic settings.

Although these studies were conducted with different populations, all demonstrated the use of portrait drawing to assist patients with self-expression. Glaister (1996) studied married women with a history of sexual abuse. The women were able to use portrait drawings as a medium for talking about their sexual abuse and for becoming more active, empowered participant in their counseling program. Alter-Muri’s work (2007) involved Alzheimer’s patients who used self-portraits to identify their strengths

and weaknesses in the early stages of their cognitive decline, and veterans with post-traumatic stress disorder who used portraits as a way to ground themselves and promote healing. Hanes (2007) used self-portraits with chemically dependent clients as a means of helping the clients face their addiction. Hanes found the clients' self-portraits were true-to-life representations of the diseased aspect of their life, and recommended the use of self-portraits as a therapeutic intervention to assist clients in dealing with painful realities of the addictive cycle. Martin's pilot study (2008) of the effect of portrait drawing on the communication skills of children diagnosed with autism spectrum disorder (ASD) revealed that the drawings helped the autistic children communicate more effectively.

The single nonclinical study of art therapy by Miller (2010) involved two art therapy in-service workshops within six weeks at an acute care hospital and teaching facility in New York. The workshop participants reported that they gained a better understanding of art therapy, and at the end of the workshop, viewed art therapy in-services as an "important means of building collaboration and cohesion among team members, and strengthen interdisciplinary dialogue between the staff and the art therapist" (p. 53).

Art Therapy and Childhood Obesity

Health promotion with children requires a variety of strategies that focus on adopting a healthy lifestyle. In the primary health care setting, health care providers have opportunities to provide counseling aimed at the prevention of childhood obesity (Kubik, Story, Davey, Dudovitz, & Zuehlke, 2008). In 1999, McDonald, Antunez, and Gottemoeller proposed that the "arts can act as a catalyst to make health education (and promotion) memorable and enjoyable" (p. 292). Despite this optimistic outlook, there are

few studies in the literature that directly address the use of art therapy in the treatment of obese children. As summarized below, small studies share the common objective of encouraging obese children to express their emotions, and diverge on the type and extent of quantitative assessment utilized in the studies.

The most recent study, conducted by Anderson in 2013 demonstrated how art therapy can uncover mental, health, and psychosocial concerns that contribute to children's weight challenge. The data revealed that the 13 participants had obesity-related experiences and stress from bullying, low self-worth, and family difficulties that prohibited their ability to adhere to their weight reduction regimen. The findings concurred with previous research that had shown that obese children struggle with multiple health issues, body image concerns, and psychosocial issues such as low self-worth from teasing (Daniels, 2006; Hassink, 2007; Hayden-Wade et al., 2005; Puder & Munsch, 2010; Rosal et al. 1998). As a nonpharmacological intervention, the art therapy provided important feedback to the interdisciplinary team about additional supportive services for children such as psychological counseling.

In contrast, Anzules et al. (2007) conducted a six-week program in Switzerland in which art therapy was integrated with cognitive-behavioral therapy (CBT), medical treatment, and physical activity. The program focused on awakening the body, renewing contact with the body, and bringing awareness to it through art therapy. Beyond the art therapy and semistructured interviews, the researchers used a standardized instrument—Coppersmith's Self-Esteem Inventory (SEI)—to measure the impact of the art therapy on the 14 participants' self-esteem. After six, two-hour, weekly sessions, the obese patients showed moderate, clinically significant improvements and were able to express

their emotional experiences in different approaches through pictorial and bodily expression. However, Anzules et al. were unable to discern if this improvement resulted from the art therapy, cognitive behavioral technique, or the combination of both approaches.

The research of Rosal et al. (1998) also involved mixed-methods art therapy and group counseling sessions with 16 obese teenagers and use of standardized instruments, the Children's Depression Inventory (CDI) and the Rosenberg Self-Esteem Scale (RSE). The researchers reported the participants received more benefits from sharing experiences and learning from peers than from the nutritional curriculum. The group counseling was helpful in providing a supportive peer group in which to discuss psychological and emotional issues, explore difficult emotions and situations, and share personal experiences and perceptions of their bodies, although the impact of the group was limited in terms of weight loss.

Cockle's 1994 study was a simple, single-case study in which the self-portrait technique was used to assess improvement in an overweight, six-year old Asian boy who appeared sad and withdrawn. The boy attended eight weeks of group art therapy and created self-portraits that described the positive changes in self-concept that took place over time within a therapeutic, client-centered environment. Over time, Cockle noted the artwork revealed that positive change such as signs of hope, security, strength, self-assuredness, self-concept, and personal power occurred through the art, colors, and intensity of emotion expressed in the portraits. Cockle theorized that art is healing and helps to externalize experiences of self and the surrounding environment onto a blank paper.

Art Therapy and Eating Disorders

According to Bresler (1988), obesity is classified as an eating disorder, although physiological influences are believed to play a greater role in the development of obesity than in anorexia or bulimia. All eating disorders, however, have major physical effects (Bresler, 1988). Individuals with anorexia experience cardiovascular, gastrointestinal, dental, and endocrine problems, as well as electrolyte imbalances. Individuals with bulimia can suffer from hypoglycemia, dental problems, hypokalemia, and problems with the esophagus and salivary glands. Obesity is associated with hypertension, diabetes, impaired respiratory function, bone and joint diseases, and cardiovascular disease.

There have been a number of studies that investigated the use of art therapy with patients who suffer from eating disorders. The most recent research, conducted by Guez, Lev-Wiesel, Valetsky, Sztul, and Perner in 2010, explored the use of self-figure drawings in women with either anorexia or bulimia as a short, nonintrusive adjunctive tool to evaluate eating disorders. However, this study did not include any standardized approaches to evaluating psychological disturbances such as anxiety, depression and panic disorders.

In 2003, Rehavia-Hanauer conducted a similar qualitative study that examined the use of art therapy to identify the psychological concerns of 10 women with anorexia nervosa. The art therapy revealed conflicts the researchers believed to call for improved diagnostic and therapeutic tools. Two years earlier, Thompson (2001) described the use of verbal and nonverbal modalities such as dance/movement therapy and art therapy in the case studies of three women with eating disorders. Thompson found that the different modalities interchangeably were an effective way to foster creative growth and personal

change in a group setting. The group setting contributed to the holding environment and assisted in creating supportive relationships among the group members.

The unique research in this group of studies is the work of Frisch, Franko, and Herzog (2006), which utilized eating disorder programs as the unit of analysis. The 13 programs that completed the self-report survey revealed that arts based therapies were used weekly in the treatment of eating disorders and was a tool for self-discovery, self-exploration, and self-expression. Clients were able to use the arts-based therapies as a healthy way to express emotions and cope with issues such as body image, depression, and self-worth. However, the research suffered from a major weakness because the survey did not determine if each program employed a standardized curriculum.

Summary

The literature on childhood obesity revealed a growing epidemic of obesity in American children, who may be the first generation of children who do not live as long as their parents. The obesity epidemic is more prevalent in African Americans, who have the highest rates of excess weight in the nation and are at a greater risk for serious diseases.

Health care interventions for childhood obesity include nutrition education, psychological counseling, physical activity, bariatric surgery, and pharmacotherapy. Despite the availability and use of these multimodal interventions, recent reports suggest that the standard weight management programs are not working effectively, and the prevalence of childhood obesity in the U.S. continues to rise.

There is an urgent public health need for more successful strategies that can encourage healthy lifestyles and reduce obesity in American children. Additionally,

African-American children may receive different messages about the ideal female figure, which can result in less concern about weight issues in young African-American children approaching puberty (Lawrence & Thelen, 1995). Hudson (2008) found African-American girls believed that being overweight was normal or ideal, and this perception encouraged them to be less physically active than non-obese girls. Whereas other investigator, have found that African-American adolescent girls have express preference for a body size in the normal weight range (Baturka, Hornsby, & Schorling, 2000; Katz et al., 2004). Art therapy has the potential to provide unique access to the context of living with obesity and to self-perception, which is known to be a major determinant in the quality of decisions made by adolescents (Loughnan et al., 2010). Understanding their experiences can lead to more effective weight loss strategies for this at-risk group of children.

CHAPTER 3

Methods

The purpose of this phenomenological research study was to investigate the experiences of African-American girls between the ages of 12 and 17 years old who struggle with obesity. The research was guided by a primary research question: What is the life experience of African-American girls with childhood obesity? The collected data included interviews and the girls' three drawings depicting their home environment, school environment, and self-perception as a girl with obesity as well as their comments about the art therapy experience.

Research Design

The purpose of phenomenological research, as Denzin (1989) suggested, is to capture the voices, emotions, and lived experiences that alter and shape the meaning individuals give to themselves and their life experience. The phenomenological perspective is concerned with generating plausible insights that "bring us into direct contact with the world and are not concerned with predicting or explaining human experience" (Van Manen, 1990, p. 138). It also supports and illuminates the essences of the youths' experiences permitting that which is invisible to be visible (Kvale, 2008). Qualitative methods have several advantages when looking at a particular phenomenon primarily, they allow the researcher to "see through the eyes" of the people being studied.

Estrella and Forinash (2007) argued that when researcher and participants work in tandem, participants' experiences are validated, which can empower individuals to take constructive action in their own lives. Through the art therapy experience provided in this study, a safe, therapeutic space was created in which the girls had the opportunity to

verbalize, identify, and crystallize their life experiences with obesity. This research also supports the need for medical and public health practitioners to acknowledge the thoughts and feelings of teenagers with obesity, as well as how medical and public health practitioners can assist with treatment, helping patients and clients achieve a better understanding of what it means to *be* a person living with childhood obesity.

Participants

Purposeful sampling was used to select an information-rich sample of self-identified African-American girls who had first-hand experience living with obesity. The participants needed to meet the following eligibility criteria: (a) willingness to participate in the study, (b) currently enrolled in the facility's weight management program, (c) between the ages of 12 and 17 years, and (d) body weight greater than 95th percentile for their body mass index.

A recruitment poster, approved by the health facility's public relations office (Appendix A), was posted in the weight management center exam rooms was used to recruit the participants. Direct referrals from health care providers at the pediatric wellness center were also solicited.

Telephone screening was conducted to briefly introduce the study, ensure that the potential participant and her parent(s) understood the purpose of the study, and to determine interest and eligibility to participate in the study. A total of 14 girls who were screened met the eligibility criteria. After the initial telephone screening, eligible participants were scheduled for the first research session. At the first session consent and assent forms (Appendices B, C, D, E, and F), were distributed giving parent's consent and child's permission to participate in the study. The start of the pre-interview however

did not obligate them to participate in the study. In addition, the participant had to sign a separate assent form and consent form as waivers for the art to be used for educational purposes and/or publication (Appendices C and E).

Procedures/Data Collection

The study utilized three art therapy sessions to explore the girls' self-perceptions and lived experiences as adolescents with childhood obesity in the contexts of the home and school environments. This study took place in a medical setting in Washington, D.C. The sessions were conducted in either a pediatric hospital examination room or an affiliated health center's conference room at a time convenient for the girl and her parent(s).

At the beginning of the first session, the researcher reviewed the consent and assent forms and obtained permission for each girl to participate in the study. The parents and participants were given copies of their signed forms.

After the forms had been signed, copies distributed and the parent(s) had left the room, the researcher conducted the first of three 30- to-45 minute research sessions. In each session, each girl was given an art directive and then asked to draw a self-portrait in response to the directive. The directives were organized as follows:

1. Home: How do you experience your day at home regarding your weight?
2. School: How do you experience your day at school regarding your weight?
3. Self: How do you see yourself as a teen with childhood obesity?

The participants were provided with drawing materials. The materials included 8.5"x 11" paper, Crayola Multicultural crayons, Crayola markers, and Crayola colored pencils. The participants were allowed approximately 30-45 minutes to respond to each

art directive. Once done, the participants were asked to provide a brief description that reflected the art experience. After each art directive was completed, the researcher used the guiding questions to inquire about the participant's art. The researcher asked each girl to describe her drawings, her feelings about her experience in the selected environment, and her feelings about the artwork. Thick description (Geertz, 1973) was gathered during discussion of the girls' artistic creations which reflected their perceptions of their home experience, school experience, and self-image. All data were organized under pseudonyms and secured on the researcher's laptop, which was stored in a locked room at the facility and password-protected.

Data Transcription

The researcher recorded the individual, open-ended interviews on a Craig handheld IC recorder and then entered the recordings onto her personal laptop computer. Audio recording of the open-ended interviews provided the researcher access to the participants' tone of voice, pauses, and the emotional charge given to any words or experiences.

After each art therapy sessions, the researcher transcribed the taped material. The researcher transcribed the audio recordings, analyzed them for common themes, and then coded them thematically to capture the essence of each participant's experience. Once themes were identified, they were examined for any connections. Shared experiences were explored by the researcher according to the frequency with which they occurred in the data.

Participants' Artwork

The researcher photographed all the girls' art work at the end of the art therapy sessions. To ensure participants' confidentiality, the researcher marked each piece of art work with assigned number. After the artwork was photographed, participants were given the option to keep the artwork or to leave it with the researcher.

Photos of the participants' artwork were uploaded to the researcher's laptop and deleted from the camera's memory card. A reference key that linked participants with their de-identified data, which was kept offsite in a secured office.

Data Analysis

Thematic analysis was used to analyze emerging themes in the artwork, open-ended interviews, researcher's field notes, and observational data. The interviews transcripts, including words and selected features such as pauses and laughter, were printed. A preliminary "start list" (Miles & Huberman, 1994) was then developed for coding from the relevant literature, the study's research questions, and the researcher's first-hand experience with similar subjects and the central themes of interest in this study: home, school, and self-image.

The analysis began with the researcher developing a sense of the whole picture by reading all of the interview transcripts and reviewing the girls' artwork. The researcher next used inductive logic to conduct content analysis on the interviews and the girls' artwork, as well as to identify recurring, emergent patterns. The researcher organized the data into meaningful, manageable themes. The researcher reviewed each interview and work of art and assigned labels to clusters of similar topics, themes, codes, and patterns in words, phrases, sentences, or whole paragraphs. The researcher searched for natural

variations in the data and worked back and forth between the data and the coding system which verified the meaningfulness of the categories and areas of potential convergence. This was a creative process that required making carefully considered judgments about what was meaningful and significant in the data (Forinash, 2004; Patton, 1987).

The data were then subjected to an in-depth review, which included highlighting quotes (Forinash, 2004) and identifying positive and negative comments. The researcher bracketed beliefs and biases, and remained open to emergent findings across the three contexts of home, school, and self.

Ethical Considerations

This research was approved by Lesley University and the facility's institutional review board (IRB). Voluntary consent was obtained from the participants' parents. Assent was given by the participants. Steps were taken to ensure that informed consent was obtained from the parents of the participants and that the confidentiality of participants was maintained throughout the course of the study.

Triangulation through multiple methods (interviews, art therapy sessions, and field notes) was used to increase the trustworthiness of this study. Purposeful sampling was used to select an information-rich sample of African-American girls who had first-hand experience living with obesity.

CHAPTER 4

Results

A total of 10 girls consented to and completed the study. An additional four girls, who had agreed to participate, did not return telephone messages and did not report for the first scheduled appointment. The girls' parents were also contacted by the researcher who left messages on their voicemail. Two parents agreed to bring their daughters to the facility, but did not report for the scheduled appointment.

The girls' weights ranged from 135 to 303 pounds. One of the 10 girls lived with both parents. One of 10 girls lived with her grandparents. The remaining eight girls lived in a single parent home. At the time of the study, eight of the girls resided in low-income housing. The girls reported little or no experience with art therapy prior to participating in the study. Thus, there was a range of experience with art making and skill level among the girls. All of the girls are identified by pseudonyms.

Table 1

Demographics of Study Sample (N=10)

Participant ID	Pseudonym	Age	Weight (lbs)	Family
1.	Cheryl	17	282	Father, mother, brother
2.	Teresa	16	218	Single mother
3.	Kim	14	393	Single mother, sister
4.	Mary	17	209	Single mother
5.	Ann	17	372	Single mother
6.	Melissa	16	298	Single mother
7.	Gina	12	175	Grandparents, siblings
8.	Judy	17	282	Mother, stepfather
9.	Sue	14	260	Single mother
10.	Lisa	12	164	Single mother, brother

This chapter displays the girls' artwork for each of the three context—s—home, school and self. Figures 1 to 10 show the portraits of the girls' experience of home and each girl's response to her drawing of being at home. Figures 11 to 20 show the portraits of the girls' experience of school and their responses to their drawings of being at school. Figures 21 to 30 show the portraits of the girls' view of self and their individual responses to their self-portraits.

The richest and most full responses from the participants are presented. The chapter concludes with themes that emerged from the girls' artwork and the interviews (Appendix F).

Experience at Home



Figure 1. Cheryl at Home.

Cheryl's response: *I see myself eating. I am tired and anxious as my parents look at me with frustration and concern. My mom is always worried for she has poor health and she doesn't want the same for me. My father gets frustrated for he knows I'm smart yet can't seem to understand why I eat ...and can't get myself together to lose weight. I look frightened. I am pleased with using my art to get this out. I feel better talking about it. Nice to know someone wants to know how I feel.*



Figure 2. Teresa at Home.

Teresa's response: *"feelings of being judged in public settings and feelings of being stared at."*



Figure 3. Kim at Home.

Kim's response: *Family supportive and non-judgmental yet feelings of sadness and a broken heart. There are feelings of the outside different from the inside happy but sad.*



Figure 4. Mary at Home.

Mary's response: *Mom supportive and non-judgmental Yet, I have feelings of concern and disappointment ... blah and fat ... Low self-esteem and depression.*

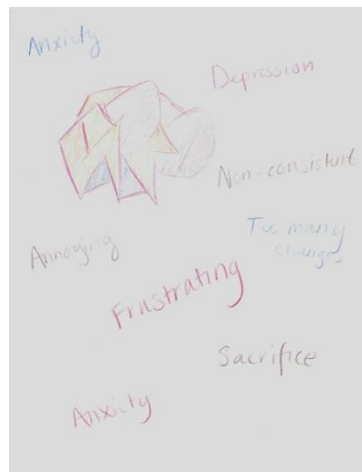


Figure 5. Ann at Home.

Ann's response: *Mom being nonsupportive and judgmental ... feelings of anxiety and frustration. Being in pieces and being depressed.*



Figure 6. Melissa at Home.

Melissa's response: *Life as in a tight ... knots. I am crying ... as sad and falling: I see a sad girl. She is crying. Looks like I am sitting ... tight ... like in a knot. I look like I am falling. Um ... I am sad.*



Figure 7. Gina at Home.

Gina's response: *Cute and happy. I look cute here. I am happy and have a smile on my face. I messed up my face. I look good here. I like it.*

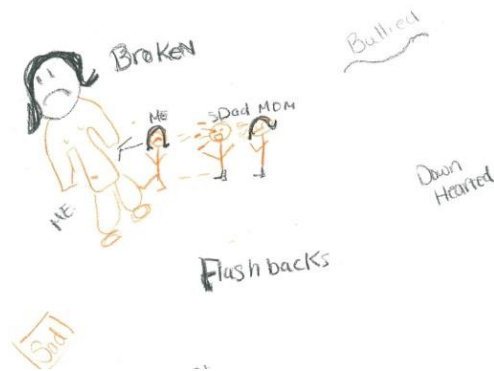


Figure 8. Judy at Home.

Judy's response: *I see me as being ... sad and broken. I feel I am bullied at home and school. This makes me feel down hearted and sad. I get the flashbacks most at home. I see me walking away and mom taking up for me.*



Figure 9. Sue at Home.

Sue's response: *What I see is my life. This is my life ... sleep, refrigerator, kitchen table, and TV. That's it. Sue acknowledges she only eats when I'm starving.*



Figure10. Lisa at Home.

Lisa's response. *Well ... I see that I have nothing to do. My brother is gone most of time but when he's home he is bad*

and tease me about how much food I eat. Seeing this reminds me of how I feel alone. I want to spend more time with my mom. She works a lot. I need to get busy and stop sitting around.

Experience at School

Figures 11 to 20 show the portraits of the girls' experience of school and each girl's response to their drawing of being at school.



Figure 11. Cheryl at School.

Cheryl's response: *Well, I see myself as being vulnerable at school. With people judging me and calling me names like ugly and fat. My vulnerability makes me feel nude ... like they can see right through me. I look like I am holding my head like it is all a blur and gives me a headache. I have to close my eyes in order not to see their stares.*

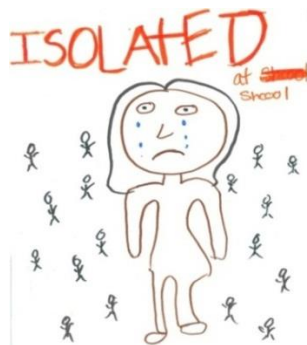


Figure 12. Teresa at School.

Teresa's response: *Feeling alone and isolated. When people are around me ... I'm alone. When I look at this I see I am alone ... and how isolated I feel at school. Gosh ... even when people are around me ... I'm alone.*

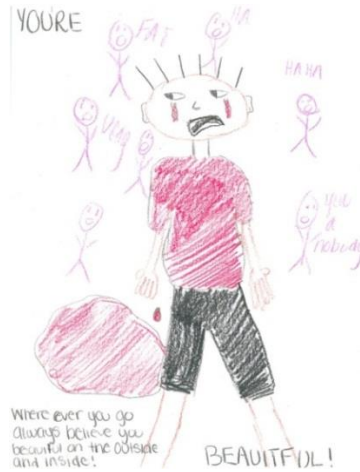


Figure 13. Kim at School.

Kim's response: *People laughing and saying mean things. I see everyone one around me is laughing and saying mean things. I cry on the outside and inside ... it look like ... feels like... blood is coming out of my eyes from the inside. A pool of tears is following me ... When I am crying ... look like I'm losing a part of me that needs to live but can't ... so I have to say to myself these words ... calling myself ... beautiful.*



Figure 14. Mary at Home.

Mary's response: *Sad. ... Okay... Looking at this drawing makes me feel like ... I'm sad. And ... I feel mostly disappointed. Fat, alone, and depressed with anger. Yeap ... That's it.*

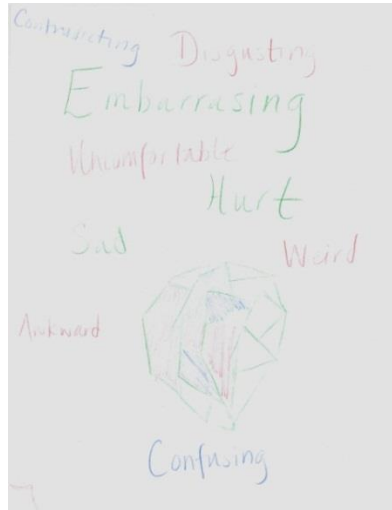


Figure 15. Ann at School.

Ann's response: *Confusion. I feel these pieces represent me and my feelings of confusion especially when I am out in public like at school. I don't like to draw a human form for it does not represent me per se ... I am not whole. I am broken into pieces. Maybe all my emotions are jagged.*



Figure 16. Melissa at School.

Melissa's response: *Here I am happy. I am smiling. Cause I love school.*

I am happy here.



Figure 17. Gina at School.

Gina's response: *Here I look somewhat happy. I made my smile half but I still look good.*

My hair is different here. My bow is bigger too. I'm not as tall here then at home.

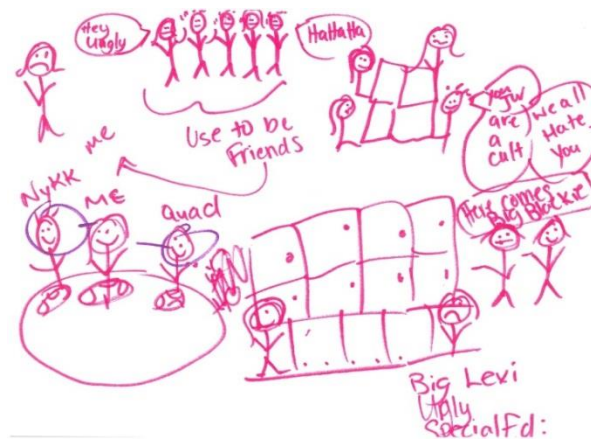


Figure 18. Judy at School.

Judy's response: *People hating on me ... smiling sometimes and most of the time sad at school.*

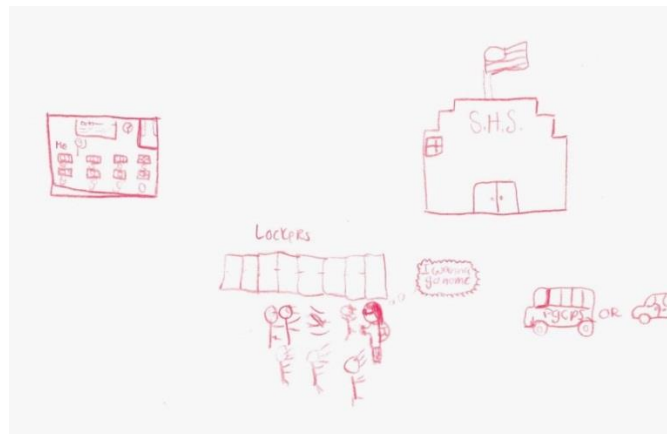


Figure 19. Sue at School.

Sue's response: *When I look at this it reminds me of how irritated I get a school ... I think of all the mean words no one wants to be called like ... fat, ugly, and ... monkey. Words no one should be called.*



Figure 20. Lisa at School.

Lisa's response: *At school I see me wanting to be happy and I think of something I like doing like math and dancing. But I see the other kids are laughing at me and calling me nasty names like ... ugly and fat. Then I'm not happy.*

View of Self-Perception

Environmental factors as well as self-perception are interconnected and important factors in understanding obesity individually from the participants' view point. If individuals do not understand their living with obesity then they are "unable to assign meaning to obesity in their life" (Ashcraft, 2012).

Figures 21 to 30 depict the girls' self-portraits and their responses to the drawings of self.

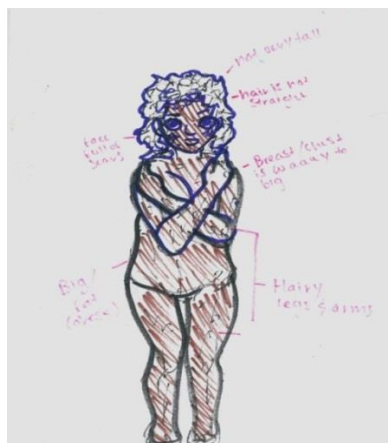


Figure 21. Cheryl's Self.

Cheryl's response: *I see myself as not feeling good about myself. I feel not attractive from my face to my height. I feel like my body is big and fat. I don't like myself. I feel like I am nude for people look at me in disgust. I feel disgusted with myself.*



Figure 22. Teresa's Self.

Teresa's response: *I see a beautiful, fun, pretty girl who wants to be me. A girl who wants to go out and not have people staring ... but staring at me for me. I'm conceited here. I look sad at school.*



Figure 23. Kim's Self.

Kim's response: *I see a happy girl on one side and the other not there. Half empty.*

Makes me think...where is the other part of me ... is somewhere out there? Probably the sad half and that's the part that wants to eat. I think that is where the other part is ... in a happy place eating.



Figure 24. Mary's Self.

Mary's response: *Disgusted. This is how I feelSkinny me, then there is a fat me, then there is me now ... bigger and disgusted. I look ... like I am shocked. I guess I am ... like how did I get this big? See ... wow... there is a skinny me inside all of this fat me.*

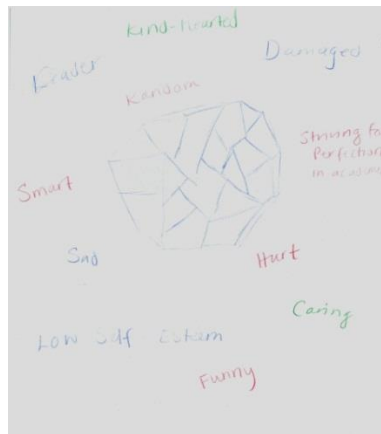


Figure 25. Ann's Self.

Ann's response: *I see many broken pieces holding on ... many words floating that describe me. ... of how I see myself. Damaged stands out for me. I see myself as random pieces. Not even complete. I see that I acknowledge I am kind hearted, smart, funny, and caring however I see there are pieces of me that are random, sad, hurt and I know I have low-self-esteem. I only striving for perfection in my academics... I figure it is the only thing I have going for me.*



Figure 26. Melissa's Self.

Melissa's response: *Melissa saw herself as a happy girl ... yeah ... I see my smile and most of the time happy. Not at home. And with myself I smile yet know there are times I have depression.*



Figure 27. Gina's Self.

Gina's response: *I am just a big head here. I see a happy girl. I am happy with myself. I see I put color in my hair and have no body. I am happier here. Probably cause I'm alone and no one tells me what to do. I can just be happy. Yeah ... that's it ... I am happy when people are not around me. All alone.*



Figure 27. Judy's Self.

Judy's response: *Confident sometimes. I see beautifulness. Look at me. A baker chef ... I see myself on Cake Boss. I will be happy and proud. I am confident sometimes. It is hard to stay confident around mean people. Yeah ... this is me and I am happy now.*

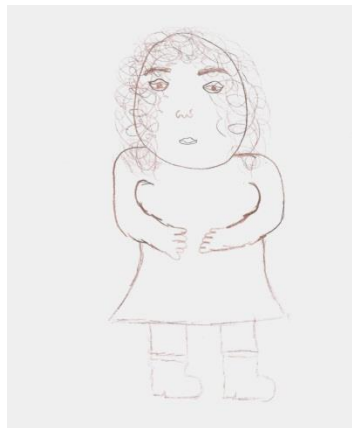


Figure 29. Sue's Self.

Sue's response: *I look irritated. My face looks fat. I didn't mean to draw the circle that big. Oh well. I see a girl who wants to be normal but other people my age only want to do one thing. My face looks ... irritated.*



Figure 30. Lisa's Self.

Lisa's response: *When I look at this ... I see me. I know I am special. I'm a nice girl. Yeah this is what I see.*

Emergent Themes

Three major themes that emerged from the home environment, school environment, and self-perception and shared by the 10 participants (Appendix G) are the ridicule and shame they have experienced from being bullied and teased, the feeling of isolation, and psychosocial issues such as depression and low self-esteem. The following is an analysis of the major themes from the open-ended interviews and artwork of this study.

Bullying/Teasing in Home and School Environment

A sense of being bullied and teased was perhaps the most pronounced of all the themes. This theme involves a variety of responses the participants dealt with in the home

and school environments. All of the girls reported that they have been shamed, ridiculed, bullied, and teased in the home environment and/or the school environment because of their weight. As Kim stated, *“They tease me all the time, they used to call me ‘big girl.’ Sometimes, they used to call me ... ugly and fat.”* Sue reported being called a “monkey” and being “*hated*” because she was “*fat*.” For Teresa, Mary, and Melissa bullying and teasing did not occur in the home environment. It has, however, occurred in the school environment. As Teresa said, *“There is no judgment in the house ... my family knows it would lower my self-esteem if they judge. We all have been judged. No judgment from family. Only judged by strangers.”* With the exception of Cheryl and Lisa, the girls’ parents and caregivers were overweight or obese themselves. However, seven of the girls’ family members were not kind at home. Cheryl reported that her parents *“look at me disapprovingly.”* Lisa’s brother teased her and told her *“You’re not like us.”* Ann’s mother told her that she *“gets looks about my weight”* and stated *“mean things like ... you show up when food comes out. Slow down. Your pants are too tight.”* Judy reported being bullied by her step-father; *I am bullied at home and called mean names, like ...fat, stinky, and ugly. It really hurts. I am yelled at when I am sitting down and trying to relax. Stuff like...get up you big, fat, lazy girl. I can’t even relax even at home. I feel bullied at home and school.* “The participants talked about their experiences of being ridiculed by family members, peers, and even a school’s gym teacher. Kim shared, *“Like...when I’m in PE and they are picking teams ... I’m the last one to get picked. Then the coach has to put me on a team. That is when everyone [is] ‘joning’ on me the most. They say mean things like ... you’re a nobody. I think the coach thinks it funny too. He be laughing. Like he is using me to get back at a group of kids... Then everyone on that team gets mad*

when I'm put on their team. It hurts." Kim continued: *"People will judge you and stare. It is like they stare right through me. They stare with disgusting looks on their faces when my mom and me go out ... like to dinner ... people look at us with judgment on their faces. They stare."*

Nine of the girls in the study reported being teased because they were "fat", and seven reported they were accused and/or seen of being "lazy" and "greedy" because of their weight. However, seven of the girls in the study reported being involved in physical activities at school and/or at home. The girls who did not take part in physical activities expressed a desire to be involved in some recreational or team activity, but they were encumbered by challenges with transportation, finances, and safety concerns in their local environment. The prevalence of bullying and teasing was in the school environment.

Isolation, Shame, and Ridicule

Most of the participants were able to affirm they had been or had a feeling of being isolated, feeling shamed or ridiculed. For instance, Teresa stated, *"when I look at this I see I am alone and how isolated I feel."* Judy shared, *"I see me as being sad."* The participants' artwork as well as their comments about their experience of living with obesity identified the importance of being heard, understood, co-existing, and having a sense of belonging in the context of their environment. Kim stated, *"Maybe if people see my broken heart they will care."*

Eight of the girls reported that their weight issues had led to limited social life and a feeling of being isolated at home, at school, and with their self- perception. Five of the participants felt having obesity could be emotionally isolating, as family at home and peers at school isolated them by not being supportive or not understanding their

experience with their health condition. Cheryl said *“It makes me feel so vulnerable, alone. I’ll put a paper bag over my face. I feel like a ghost. They stare...Like I am not there.”* Ann felt alone even when there were other people around her. Sue felt isolated because her life at home was *“limited to television and eating.”* Lisa reported that she *“stayed in her house all the time”* because she could not go out in her neighborhood. Cheryl also stated, *“The students can be so mean and make fun of me. It never ends. I try to stay to myself... makes me feel sad, and I don’t like going to school. I have thoughts of wanting to be alone or go somewhere and hide.”* Kim said: *“People will judge you and stare. It is like they stare right through me. They stare with disgusting looks on their faces when my mom and me go out ... like to dinner ... people look at us with judgment on their faces. They stare.”* Isolation, ridicule, and shame about their weight were evident in their artwork. All of the girls’ drawings depicted their sense of isolation even while with others at home and/or at school. The sense of isolation, ridicule, and shame was prevalent in the school environment. All the participants except Teresa included words such as “isolated,” “sad,” and “depressed” in their images. The lingering emotional damage was evident also through the girls’ nonverbal expressions as well in the tone of their verbal exchanges. Overall, the girls’ artwork emphasized their concerns, the various psychosocial factors that were outlined in the literature, and the potential of art therapy to provide a medium for exposing very difficult feelings and emotions in routine life situations.

Psychosocial Factors

Teresa and Melissa reported a very positive view of themselves as beautiful, confident, flawless, happy and proud. However, nine of the girls reported a variety of

negative psychosocial issues related to their lives as young girls with obesity. These included sadness, depression, vulnerability (being scared), low self-esteem, and feeling weird, confused, angry, irritable, damaged, doomed, disgusted, alone, broken in pieces, half empty, and suicidal. The intensity of these feelings was expressed by Kim who said:

I see everyone one around me is laughing and saying mean things. I cry on the outside and inside...it look like ... feels like... blood is coming out of my eyes from the inside. A pool of tears is following me. When I am crying... look like I'm losing a part of me that needs to live but can't... so I have to say to myself these words...calling myself ... beautiful.

Four of the girls reported a distorted sense of their bodies. Cheryl reported "*being or feeling nude*." Kim drew her self-portrait with half of her body missing. Ann stated she felt like her body was "*broken pieces*"; and Mary reported although she was "*fat*," she had no body and "*felt like a ghost*."

Self-Image

Five of the participants had a positive sense of self-perception and made positive self-statements when they were doing their individual portraits. The participants acknowledged their need to have self-esteem and confidence, even if it did not come from others. Judy shared, "*I am confident sometimes. It is hard to stay confident around mean people*." Ann shared, "*I acknowledge I am kind hearted, smart, funny, and caring however I see there are pieces of me that are random, sad, hurt and I know I have low self-esteem. I [am] only striving for perfection in my academics. I figure it is the only thing I have going for me*." The self-analysis of their art work provided insight to their

condition, as well as hints of their need to have self-esteem as a way of “*being*,” which is best shared by Lisa, “*I know I am special. I’m a nice girl. Yeah this is what I see.*”

There was very little discernment or cultural context that emerged from the girls’ art work. Only a few participants, Cheryl, Teresa, Kim, and Mary used the multicultural crayons to color in their skin for the school environment drawings. Only participant Mary shaded in her color of skin at school and in her self-portrait. Furthermore, there was very little discernment or thought of the cultural context of their obesity displayed in the participants’ artwork. This may reflect the participants’ awareness of how their environment and weight can change, while physical features such as color of skin do not change. The findings affirm that these overweight African-American girls may have been less conscious of the color of their skin and more conscious of the feeling of being isolated, feeling depressed, and having low-self-esteem and being ridiculed and shamed as they were bullied and teased about their body size in their given environments. The psychological impact and residual emotional effects of being overweight were more relevant than their self-identification of being African-American.

Six of the girls from this study expressed a negative self-perception about their weight. Only four participants (Teresa, Melissa, Gina, and Lisa) shared that they were satisfied with their bodies at home while dissatisfied at school. Six participants were dissatisfied with their weight both at home and at school. Most of the participants drew their bodies as being thin both home, school, and self. While eight of the girls drew themselves as being slim in their environments, Cheryl and Mary were the only participants to draw their bodies as having wide body shapes at home and at school.

Cheryl, Kim, Mary, Ann, Judy, and Sue discussed being dissatisfied with their weight at home, at school, and their self-perception.

Participants' Reflections on Art Therapy

One of the fundamental principles of art therapy is that art assists in the expression of thoughts and feelings that would not otherwise be expressed. The girls reported that doing the art therapy sessions *"it was fun."* *"I am pleased with using my art to get this out. I feel better talking about it. Nice to know someone wants to know how I feel."* *"I like this drawing; [it] shows how I feel."* Even though the participants reported mixed feelings about their lived experiences with obesity, all of the participants reported that the art therapy sessions provided a place where they were able to share, as well as express their feelings as seen in the visual imagery that emerged from the sessions.

When the participants were asked how they felt about the art therapy, nine participants responded positively and doing the art was beneficial in helping them share their stories about living with obesity. Three participants shared, *"doing this art makes me feel like I have something good I can do. It is nice here to talk. I feel I can talk about how I feel."*

All of the girls reported that the art therapy sessions provided a safe place to share their feelings as well as responded positively saying the art therapy sessions were beneficial in helping them share their stories about living with obesity.

CHAPTER 5

Discussion

The guiding questions for the study were: What is the life experience of African-American girls with childhood obesity and how can art therapy assist in understanding the experience of African-American girls with childhood obesity? Two related subquestions were incorporated in the study: How can art therapy help public health professionals better understand the experiences African-American girls living with obesity? How can this understanding be used in weight reduction programs designed for children with obesity?

While many studies have explored children with obesity, few of the studies have explored the context of the home environment, the school environment, and self-perception with the use of art therapy to explore lived experiences. No studies have directly explored all of the concepts together among African-American girls with obesity.

The study findings support the literature which has shown that obese children deal with multiple health issues, body image concerns, impaired social development, and psychosocial issues such as low self-esteem and teasing (CDC, 2011a; Daniels, 2006; Gundersen et al., 2010; Hassink, 2007; Hayden-Wade et al., 2005; Hudson, 2008; Puder & Munsch, 2010; Rosal et al. 1998; Sanderson et al., 2011; Wang & Lobstein, 2006). The stigma from being obese exerted a negative influence on the psychological health and social life of the girls in the study, and is consistent with findings reported by Goldfield et al. (2010). Data analysis revealed that all the girls suffered negative consequences from their weight be it at home, at school and with their self-perception. The participants in this study experienced a sense of shame, were ridiculed, bullied,

teased, socially isolated, were depressed, and had low self-esteem as a result. Evidence offers an understanding of childhood obesity from the perspective of the participants which may provide direction for addressing his health epidemic.

In addition, having the negative influence of a difficult home environment, living with a single parent who may also be obese, and low socioeconomic status as reported in this study had been previously reported (Anderson & Butcher, 2006; Cawley, 2006; Chambers et al., 2009; Griffith, 2009; Puder & Munsch, 2010; Strauss & Knight, 1999).

Previous research suggests that children's reactions and experiences vary depending on the contexts in which they have the experiences (Anzules et al., 2007; Gundersen et al., 2010). This study's findings varied among the participating girls and within each context of home, school, and self. Some girls in the study viewed home as a place where they encountered bullying, teasing, and poor parental support, while others felt loved and supported by their families. Some girls had a positive association of food with home, while others reported feeling very lonely at home.

With regards to school, the girls reported negative emotions associated with being bullied, teased, and stared at by their peers. This affected their school attendance and increased their sense of loneliness. Some girls were able to maintain a positive self-image, but most spoke of low self-esteem, feeling depressed, and felt very isolated. However, at school, some girls reported the positive influence of a few teachers who would allow the girls to sit in the classroom to eat their lunch and avoid being stared at by peers. The self-portraits of the girls suggested that most of them desired to feel good and have a sense of belonging within their environment as well as with their self-perception.

Social Isolation

The social isolation experienced by most of the participants has been reported in previous studies (Cassidy et al., 2013; Perez & Warren, 2012), which found parents of obese African- American girls perceived that their daughter's weight excluded her from social activities and impaired her ability to have a normal social life. Davis et al. (2008) had suggested obese African -American children “may engage more in internalizing behavioral problems” (p. 64). These feelings may have been repressed by what Young (2004) called the “strong black woman” filter of African-American women.

Camic (2008) suggested that the arts play a role in health promotion by decreasing a growing sense of alienation within the workplace and in the community. In this study, art therapy provided the girls with a safe way to express their feelings of isolation and depression. Furthermore, art therapy- in contrast to standardized assessment tools- provided the participating girls with a medium through which they could share their personal experience of being isolated from the outside world.

Cultural Factors

Research has shown that African Americans as a group have a greater tolerance for higher weight and feel less pressure to achieve thinness (Caprio et al., 2008; Plybon et al., 2009). In this study, these cultural norms were evident in some of the drawings and comments by some of the girls, who viewed themselves as “big, beautiful, awesome, confident, attractive, and pretty.” Some girls, Teresa, Melissa, and Lisa, said they were happy with their bodies most of the time and did not care if people on the “outside” were not happy with their appearance. Others like Cheryl, Mary, and Ann identified their frustration with wanting to obtain their desired weight as an encouraging factor to lose

weight and to be healthy, having a sense of belonging, and being able to go outside without being stared at in public places.

Distorted Body Image

In this study, four girls' self-portraits revealed a quite unusual presentation of their bodies that suggested a distorted body image. Kim's self-portrait showed only one side of her body because she was "*half empty*." Cheryl drew herself nude because she felt nude, even when she was fully clothed with other people around her. Ann drew her body in each drawing as broken pieces. Mary drew her "*real*" body hidden inside another body because "*there's a skinny me inside of this fat me.*"

These findings support the guidance set forth by Furth (1988) that art therapists should pay attention to what is odd or missing in drawings, as well as proportions, size, shape distortion, and perspective. More pertinent to this study of girls with obesity, Apfeldorfer (1994) had described the "tendency for obese individuals to dissociate themselves from their bodies" (p. 72). Anzules et al. (2007) also reported in 2007 that "Perception of the body lies at the heart of problems experienced by obesity sufferers and that overweight or obese individual can suffer from a distorted body image" (p. 72).

Parental Involvement

As acknowledged by Venture (1977), one of the drawbacks in art and play therapy is the lack of direct parent involvement. In this study, the lack of parental involvement has been recognized as one of the study's limitations. Despite this, the girls' drawings of their home environment provided important insights into both the positive influence of having a nonjudgmental family and family support, and the negative impact of family distress, lack of parental support, and blatant criticism about their eating habits

and weight. Three girls reported that although they were depressed about the teasing at school, having a supportive family at home helped them to not care as much about what was happening at school. Two girls spoke of feeling accepted by their family members, who could relate to being overweight or obese and also being stared at in public. Two girls said that their mothers were good role models because they were confident with their weight, body size, and positive body image.

Prior research has shown parental involvement in family-based programs is predictive of long-term success with weight loss (Heinberg et al., 2010; Wadden, Butryn, & Byrne, 2004). Strauss and Knight (1999) noted that although the role of the home environment in the development of childhood obesity has been recognized “Few studies had documented the extent to which the home environment contributes to childhood obesity” (p. 85). Strauss and Knight further commented the home environment is “a critical factor in the development of childhood obesity” because minority children and children of lower socioeconomic status typically have the poorest home environments and highest levels of obesity (p. 85).

Gibbons (2007) emphasized a need for extensive parenting education and intervention in childhood obesity. Gibbons reported on the family’s inability to make effective change due to lack of skills and knowledge; and the family’s defensive stance, in which they felt accountable or blamed for their child’s weight or affected by previous unsuccessful attempts at making change. The findings in this research study are consistent with Davis’ (2004) focus group results that reported that African-American parents may be uninformed of their obese child’s negative experiences. In such experiences, these behavioral problems are internalized, and the child’s health was

compromised. All girls reported of not sharing their daily experiences with their parents and being unable to express their feelings about their weight concerns and frustrations openly.

Hudson (2008) noted some parents discourage healthy eating behaviors. Larson (2008) emphasized parents control many of the factors that contribute to childhood obesity, such as purchasing food and accepting sedentary activities. Larson also observed that parents from low-income and minority populations were insufficient economically, educationally, and geographically in terms of the accessibility of healthy options for their children.

Self-Perception

Self-perception is a main factor in the quality of decisions adolescents make (Loughnan et al., (2010). Adolescents are influenced by their own views of themselves and their awareness of the world around them. Influences such as social relationships, structural forces, societal influences, and life experiences (Sorensen et al., 2007) contribute to the development of self-perception and it reflects how peers understand and use information about each other. As a phenomenological researcher, it was not my intent to analyze the participants' artwork; however, it was my intent to use art therapy to understand the phenomena of childhood obesity. After the session, each participant was asked to share with the researcher what she saw in her artwork.

The artwork shared by the participants supported some theories of art therapy. As I looked at the girls' art work, I observed that eight of the participants drew themselves as slim or of average size. According to Manus and Killen (1995) obese children often draw themselves as being slim or of average weight. This supports that

most of the girls were indeed not happy with their weight. This finding conflicts with previous studies that have reported African-Americans tolerance for higher weight and having less pressure for thinness (Caprio et al., 2008; Plybon et al., 2009).

Many of the girls' drawings showed missing body parts, notably their feet. Research conducted many years ago suggested that missing body parts in art work represent a sense of helplessness and feelings of dependence (Buck, 1948; Evans & Marmorston, 1963; Jolles, 1952; Modell & Potter, 1949). All the girls in this study expressed a desire to be accepted for who they are verses being seen for their size and feeling a lack of social acceptance in their environments.

This research study suggests that greater understanding of the lived experiences of obese African-American girls can help multi-disciplinary health care teams provide more sensitive, appropriate, effective, culturally competent medical and psychological care that will help these young women live a more positive, healthier life.

Recommendations

These findings support previous recommendations that lifestyle, personal habits, emotional issues, and body image must be integral components of the medical treatment of obese children (Anzules, et al. 2007; Cockle, 1994; Malchiodi, 1998; Rosal et al., 1998). The study findings suggest that:

Integration into Childhood Obesity Programs

This study findings are useful to help inform theory which can be used to create and enhance multidisciplinary therapeutic approaches to intervention for African-American girls with obesity. Art therapy is an outlet for expressing their internal feelings of isolation, bullying, shame, and psychosocial factors such as depression to provide

insight into these feelings and be used to employ ways to motivate them to change behavior.

This study results suggest that art therapy provides a creative outlet as well as inform the multidisciplinary medical teams with a nonpharmacological, adjunctive modality that provides access in gaining insight into the patient's experience. This can employ motivation and support as well as a way to assist in their being able to adhere to the program. This access to lived experience can provide important psychosocial information from the child's point of view, critical insights into the environmental and cultural factors that may inhibit the children's ability to adhere to a weight loss regimen, and perhaps most importantly, their need for ongoing mental health assessment and treatment. This access through art therapy also acknowledges and respects the whole child, who deserves the respect of the health care team.

Acknowledging one's personal narratives can be a source of healing and can guide children through a process that honors individual stories (Potash, 2005). Even exploring negative influences through art with narratives can provide a powerful source for innovative action (Collie, Bottorff, & Long, 2006; Estrella & Forinash, 2007; Potash, 2005). In a past study one's negative lived experiences were suggested as a way to provide the fuel needed to make meaning out of these experiences (Boals, Banks, Hathaway, & Schuettler, 2011; Collie et al., 2006). Art-based narrative inquiry can also help marginalized groups recognize inequality. Understanding this inequality can involve giving marginalized groups a voice to empower and provide change (Estrella & Forinash, 2007). Additionally, art therapy sessions can also support innovative approaches to traditional solutions because art activities can be perceived as less

threatening than talk therapy, and can be co-created between the art therapist and client (Selekman, 1997).

Cultural Sensitivity Awareness

There is an acute need for culturally sensitive weight reduction programs for African-American children, who are suffering the effects of high rates of obesity. This need was previously reported in Baskin (2001) and Kumanyika and Grier (2006). The results of their study suggested that obese African-American girls may be struggling to reconcile cultural and societal norms in body size. Health care professionals who work in pediatric weight reduction programs can incorporate knowledge and training of adolescent development and cultural sensitivity training into treatment recommendation as well as assist them in understanding how to utilize the two languages of art therapy: verbal and visual. According to Riley and Malchiodi (2002), such understanding can assist individuals in the search for solutions to problems and negative experiences through verbal and visual means.

School Policy

Schools must increase their efforts to prevent the bullying of children with obesity and to promote healthy eating. The findings from this study showed that the school environment was the primary place where the girls in the study were subjected to relentless ridicule, shame, bullying and teasing because of their weight. In previous work, Anderson (2013) had suggested schools can play a role in managing teasing and bullying of children with obesity, promoting healthy eating, providing healthier food options, and strengthening school policies that involve family participation and collaboration. Gundersen et al. (2010) concluded that policies and programs need to help

obese children build their resources and educate them on how to cope effectively with psychosocial stressors. The effects of stress on children and adolescents should be taken into consideration when evaluating the benefits and costs of different social policies and programs (Gundersen et al., 2010).

Limitations

The study was limited to African-American girls ages 12-17 with childhood obesity, who were residents of the Washington D.C. metropolitan area. Since the study sought to understand the experiences of urban African-American girls with childhood obesity, the findings are contextualized and not meant to be generalized to other populations of American adolescents.

The study was limited in duration, and was not longitudinal in design or a full-scale ethnographic study that may have included the girls' families and friends. The study was not designed to identify causal or predictive relationships involved in the treatment of girls with childhood obesity. And since the research did not assess whether art therapy was able to assist with weight reduction, no follow-up weight data were collected.

Areas for Future Research

This research with 10 African-American girls living with obesity contributes to and increases our knowledge of the lived experiences of African-American girls with obesity. However, given the gravity of the growing pediatric obesity epidemic in the U.S., future research efforts must focus on improving the ability to better understand the complex phenomenon of African-American children with obesity and developing more effective medical and psychological interventions.

Potential areas for future research might include:

1. The use of art therapy in family counseling for obese youth and their parents.
2. The effect of cultural norms on the receptivity of minority youth to weight reduction interventions.
3. The use of a secondary analysis of art work to provide a clinical assessment of the drawing s to describe potential psychosocial concerns.
4. The effect of teaching African-American girls with obesity how to use mindfulness as a means of responding to social stresses.
5. The use of art therapy in girls' circles and parent support groups that provide counseling, mentorship, support, and witness to their life experiences.
6. An expansion of this study to include a behavioral measure to examine how it aligns with the participants' drawings.
7. Comparative study for patients participating in an obesity program and receiving art therapy to patients in program only receiving standard care through the program.

Closing Thoughts

Throughout this study, my understanding of childhood obesity has been expanded, and this has increased my interest for additional awareness and insight into this phenomenon. Hearing the experiences of the participants opened up a greater understanding and knowledge in me of childhood obesity from the girls' narrative and visual viewpoint. Looking at and reflecting on their art allowed me to witness the girls'

creativity as well as gain an understanding of their personal pain and discomfort. The isolation, bullying, teasing, and the psychosocial factors such as depression and low self-esteem that they experienced heightened my sense of how these stressful issues may deplete one from their full potential that they might have realized or been provided under more understanding circumstances and environments. The girls conveyed that their lives were less happy, less filled, and less interactive because of their day to day experiences. It is my hope that the girls rise above the environmental distress, gain more supportive individuals in their lives, and gain self-confidence and self-awareness in learning how to assert themselves mentally, physically, verbally, and spiritually in their environment so they can live happier, fulfilled lives, and have a sense of belonging wherever environment they exist.

APPENDIX A
RECRUITMENT POSTER

Art Therapy and Childhood Obesity

Are you between the ages of 12-17?

Do you like art?

Are you enrolled in the Weight Management Clinic?

If you answered yes to ALL three questions, then you may be able to take part in our new art therapy program!

The weight management center is conducting a study looking at the use of art therapy and the experiences adolescents have while enrolled in a weight management program.

Each adolescent will be:

- Introduced to art therapy
- Given a space to express their feelings using art
- Explore how art therapy reflects their experiences

This is a FREE program. All art materials will be provided.

*****The art therapy study is by appointment only. *****

For more information about the art therapy program, please contact Elva Anderson MPS, ATR, LPC at 202-476-6944.

APPENDIX B
INFORMED CONSENT



**This Informed Consent Form participating in the study titled
“Using Art Therapy to Understand the Experience of African-American girls with
Childhood Obesity”**

You are invited to participate in the research project titled The intent of this research study is to ask how children between the ages of 12-17 years of age express their daily experience as an adolescent with childhood obesity.

Your participation will entail two art therapy sessions and open ended interview by the researcher meeting with you at your appointment session. Consent will be asked by the researcher to both collect your art work and audio record your interview. All demographic and identifying details of participants will be kept confidential by the researcher. Data collected will be coded with a pseudonym and never revealed to anyone else by the researcher. Only the researcher will have access to the data collected. During the interview process there will be interview questions asked by the researcher.

In addition

- You are free to choose not to participate in the research and discontinue your participation in the research at any time.
- Any and all of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.
- Participation in this research poses minimal risk to the participants. The probability and magnitude of harm or discomfort anticipated in the research are no greater in and of themselves than those ordinarily encountered in daily life.
- Please feel free to contact Dr. Robyn Flaum Cruz, rcruz@lesley.edu or 412-401-1274, Co-Chair of the Lesley University Institutional Review Board if you have any questions or concerns in connection to the research.
- Additionally you may contact the researcher Elva Anderson at 202-476-6944 or email at and also contact the Lesley University sponsoring faculty Dr. Michele Forinash at forinasm@lesley.edu or 617-349-8166.
- The researcher may present the outcomes of this study for academic purposes such as future articles, books, teaching materials, conference presentations, or in supervision.

My agreement to participate has been given of my own free will and that I understand all of the stated above. In addition, I will receive a copy of this consent form.

Participant's signature Date

Parent/Guardian (if required) Date

Elva Anderson 2501 Good Hope Rd. SE Washington, DC 20020 Date

APPENDIX C
INFORMED ASSENT



29 Everett Street, Cambridge MA 02138

This Informed Assent Form is for youth (12-17) participating in the study titled

“Using Art Therapy to Understand the Experience of African American girls with Childhood Obesity”

I am doing a study to learn about how art therapy can assist children ages 12- 17 years old who struggling with childhood obesity.

If you agree to be in this study, I will ask you some questions about your daily experience at home, school, and self as an adolescent with childhood obesity. Your art work and answers will help me to understand the experiences of adolescents with childhood obesity. In addition, allow me to gather information on the benefits of art therapy.

You may ask questions about this study at any time. If you decide at any time that you wish not to finish this study, you may ask me to stop. There is no pressure to do this study.

The questions I will ask you are only about what you think. There is no right or wrong answers.

If you sign this paper, it means that you have read this and that you want to be in the art therapy study. If you do not want to be in the study, do not sign. Being in the study is up to you, and no one will be upset if you do not sign this and/or if you change your mind later.

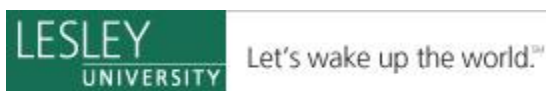
Your signature: _____ Date _____

Your printed name: _____ Date _____

Signature of researcher obtaining consent: _____ Date _____

Printed name of researcher obtaining consent: Elva Anderson Date _____

APPENDIX D**CONSENT TO USE OR DISPLAY ART**



29 Everett Street, Cambridge MA 02138

CONSENT TO USE AND/OR DISPLAY ART

CONSENT BETWEEN: Elva Anderson and _____.

Expressive Therapies Doctoral Student

Participant's Name

I, _____; agree to allow Elva Anderson
 Artist/Participant Name Expressive Therapies Doctoral Student
 to use and/or display and/or photograph my artwork, for the following purposes(s):

- ☐ ☐ Reproduction and/or inclusion within the research currently being completed by the expressive arts therapy doctoral student and for both video and written dissertation formats.
- ☐ ☐ Reproduction and/or presentation at professional conferences.
- ☐ ☐ Reproduction, presentation, and/or inclusion within future publications in professional articles or books.

It is my understanding that neither my name, nor identifying information will be revealed in any presentation or display of my artwork. I agree for the following special considerations to be upheld:

- ____ My voice can be heard as they are recorded.
- ____ My artwork may be shown as it was shared, recorded, or archived by the researcher
- ____ My artwork processes and products to be reproduced by the researcher

This consent to use or display my artwork may be revoked by me at any time. I also understand I'll receive a copy of this consent form for my personal records.

Participant signature _____ Date _____

Parent/Guardian (if required) _____ Date _____

I, Elva Anderson agree to the following conditions in connection with the use of artwork:

To the best of my ability, I agree to keep your artwork safe and treat it with the extreme respect while in my care and storage. I also agree to keep your work in confidentiality by not disclosing your identity by name and/or other identity ways in the manner agreed to in the above.

Signed _____ Date _____

Expressive Therapies Doctoral Student

Elva Anderson, MPS, ATR, LPC
 2501 Good Hope Rd. SE
 Washington, DC 20020
Eanders5@lesley.edu

APPENDICES E – F
CONSENT AND ASSENT FORMS

B. PROCEDURE

If you decide to be in this study, you will attend an art therapy session before or after your regularly scheduled clinic visit. You will attend up to 2 sessions each month for up to 6 months. Each session will last about 60 minutes and during that time you will do art work and answer open ended questions asked by the researcher.

You will be given paper, colored pencils, markers, and crayons. We will ask you to use the paper to record your daily experiences at home and at school through the use of art and/or written word. You will be asked not to write your name on the paper.

We would like to audio record your interview so we can make sure that we have all of your responses during each session. Your name will not be linked to the recordings. Instead, it will be identified with a study number. The recordings will be destroyed after they have been typed up/transcribed. Only the researcher who was with you during your session will have access to the recordings.

You will not be required to do any task that you do not want to do and no one will know the answers from your conversation or discussion of your artwork other than the researcher. We would like your permission to use the artwork and your answers to help with this study. Your responses will be anonymous and your name will not be connected to your art work.

C. POTENTIAL RISKS/DISCOMFORT

There are minimal risks involved in this study. You may feel a little anxiety about drawing if you do not feel skilled in art. You may feel discomfort talking about personal issues during your sessions. And, there is the minor risk of possible breach of confidentiality. No one will have access to your artwork or your responses except for the study researcher. Your artwork can be returned to you at the end of the study by asking the researcher. Your name will not be linked to the artwork or responses.

D. VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. There will be no penalty or loss of benefits to which you are otherwise entitled if you decide to withdraw from the study.

E. POTENTIAL BENEFITS

You may or may not benefit from being in this study. However, you may notice an increase in self-awareness and your self-esteem as you become more aware of your thoughts, feelings, and experiences and how they relate to you. You may also learn how to cope with any stigma associated with childhood obesity. The information obtained

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may help us be able help others about child obesity and assist members of the interdisciplinary team with treating childhood obesity.

F. ALTERNATIVES TO PARTICIPATION

The alternative to participate in this study is not to participate. You can continue with your treatment at health center as usual.

G. QUESTIONS – WHO TO CALL

We want you to ask questions about any part of this study or consent form either now or at any time in the future. If you have any questions about this study, call the Principal Investigator, Dr. Nazrat Mirza at 202-476-2596. If you believe you have been injured as a result of being in this study, you should call the Principal Investigator, Dr. Nazrat Mirza, at 202-476-2596. If you have any questions or concerns about your rights in this research study at any time, please call the Office for the Protection of Human Subjects at (301) 565-8452, the Chief Academic Officer, or the Chair of the Institutional Review Board of the Children's National Medical Center. The last two parties may be reached at (202) 476-5000.

H. CONFIDENTIALITY

Your child's information in the study will be kept confidential. The data will be stored securely and will be made to only people conducting the study unless participants specifically give permission in writing to do otherwise. When your art will be examined we will not reveal your name in any of the analyses performed. Your art will be kept in a locked file and computer files will be in a password protected computer in a private office. Any paper with your child's information will be destroyed after data collection for this study has been completed. We will keep the records of this study confidential. Only the people working on the study will know your name. They will keep this information in case we have to return your art and/or find you later to let you know of any new information on treatment to childhood obesity. The federal government can review the study records and medical records to make sure we are following the law and protecting the children in the study. Your medical record is confidential, but just like any medical record; there are some exceptions under state and federal law.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

In 1996 the government passed a law known as The Health Insurance Portability and Accountability Act (HIPAA). This privacy law protects your individually identifiable health information (Protected Health Information or PHI). The privacy law requires you to sign an agreement so researchers can use or share your PHI for research purposes. This describes to you how information about you may be used or shared if you are in a research study. It is important that you read this carefully and ask a member of the research team to explain anything you do not understand.

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I authorize Nazrat Mirza, MD and her research staff to create, access, use, and disclose my PHI for the purposes described below.

Protected Health Information that may be used and shared includes:

- ☐ Information that identifies you such as name, address, telephone number, date of birth, Social Security number, and other details about you
- ☐ Information that relates to your health or medical condition from your medical records
- ☐ Interviews conducted with you by members of the research team
- ☒ Audio recordings
- ☒ Other: artwork

The Researchers may use and share my Protected Health Information with:

- ◆ The Principal Investigator, other Investigators, Study Coordinators, and all administrative staff in charge of doing work for the study;
- ◆ Government agencies that have the right to see or review your PHI, including but not limited to the Office of Human Research Protections and the Food and Drug Administration;
- ◆ Children's National Medical Center Institutional Review Board.

Should your health information be disclosed to anyone outside of the study, your information may no longer be protected by HIPAA and this Authorization. However, the use of your health information will still be regulated by applicable federal and state laws.

If you agree to participate in this research study, the research team, the research sponsor (when applicable) and the sponsor's representatives, may use Personally Unidentified Study Data. The Personally Unidentified Study Data does not include your name, address, telephone, or social security number. Instead, the researcher assigns a code to the Personally Unidentified Study Data. Personally Unidentified Study Data may include your date of birth, initials, and dates you received medical care. Personally Unidentified Study Data may also include the health information used, created, or collected in the research study. The research team or the research sponsor may share the Personally Unidentified Study Data with others to perform additional research, place it into research databases, share it with researchers in the U.S. or other countries, or use it to improve the design of future studies. They may also publish it in scientific journals, or share it with business partners of the sponsor and to file applications with U.S. or foreign government agencies to get approval for new drugs or health care products.

You do not have to sign this Consent/Authorization. If you decide not to sign the Authorization, you will not be allowed to participate in the research study.

After signing the Consent/Authorization, you can change your mind and:

- ◆ Revoke this Authorization. If you revoke the Authorization, you will send a written letter

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to: Dr. Nazrat Mirza, 111 Michigan Avenue, NW, Washington DC 20010 to inform her of your decision.

- ◆ If you revoke this Authorization, researchers may only use and disclose the PHI that was collected for this research study before you revoked the Authorization.
- ◆ If you revoke this Authorization your PHI may still be used and disclosed if you should have an unexpected side effect.
- ◆ If you change your mind and withdraw the Authorization, you will not be allowed to participate in the study.

You will not be allowed to review the information collected for this research study until after the study is completed. If you are not allowed to review your information during participation in the study, when the study is over you will have the right to access the information.

If you have not already received a Notice of Privacy Practices from Children's National Medical Center, you may request a copy and will be given one. If you have any questions or concerns about your privacy rights, you may contact the Children's National Medical Center Privacy Officer at 301-572-6348.

B. WHAT WILL HAPPEN IN THE STUDY?

If you decide to be in this study, you will attend an art therapy session before or after your regularly scheduled clinic visit. You will attend up to 2 sessions each month for up to 6 months. Each session will last about 60 minutes and during that time you will do art work and answer open ended questions asked by the researcher.

You will be given paper, colored pencils, markers, and crayons. We will ask you to use the paper to record your daily experiences at home and at school through the use of art and/or written word. You will be asked not to write your name on the paper.

We would like to audio record your interview so we can make sure that we have all of your responses during each session. Your name will not be linked to the recordings. Instead, it will be identified with a study number. The recordings will be destroyed after they have been typed up/transcribed. Only the researcher who was with you during your session will have access to the recordings.

You will not be required to do any task that you do not want to do and no one will know the answers from your conversation or discussion of your artwork other than the researcher. We would like your permission to use the artwork and your answers to help with this study. Your responses will be anonymous and your name will not be connected to your art work.

C. WHAT POSSIBLE UNEXPECTED THINGS COULD HAPPEN?

There are minimal risks involved in this study. You may feel a little anxiety about drawing if you do not feel skilled in art. You may feel discomfort talking about personal issues during your sessions. And, there is the minor risk of possible breach of confidentiality. No one will have access to your artwork or your responses except for the study researcher. Your artwork can be returned to you at the end of the study by asking the researcher. Your name will not be linked to the artwork or your responses.

D. WHAT POSSIBLE GOOD THINGS COULD HAPPEN?

You may or may not benefit from being in this study. However, you may notice an increase in self-awareness and your self-esteem as you become more aware of your thoughts, feelings, and experiences and how they relate to you. You may also learn how to cope with any stigma associated with childhood obesity. The information obtained may help us be able help others about child obesity and assist members of the interdisciplinary team with treating childhood obesity.

D. WHAT OTHER CHOICES DO YOU HAVE IF YOU DO NOT WANT TO BE IN THE STUDY

Your participation in this study is voluntary. You do not have to be in this study if you don't want to. We will still continue your treatment as usual. You can decide to be in the study and then change your mind. No one will be mad.

F. HOW WILL WE KEEP YOUR RECORDS PRIVATE?

We will keep the records of this study private. Only the people working on the study will know your identity. They will keep this information in case we have to find you receive your art and/or let you know of any new information that may benefit your treatment

ASSENT

By signing this form, you agree that you have talked to your doctor about the study and understand it, and want to be in the study. You will also agree that you have been told about the risks (unexpected things) and benefits (good things) of the study, and about other choices. You may stop being in the study at any time and no one will mind and nothing will change about your medical care other than not being in the study. Please call the Principal Investigator Nazrat Mirza, MD and/or the Co-investigator, Elva Anderson, MPS, ATR, LPC at 202-476-2596 if you have any questions.

Printed Name of Participant: _____

Medical Record Number: _____

Signature of Participant: _____

Witness (to signature): _____ Date: _____
(may be investigator)

Translator's Signature (if, applicable): _____ Date: _____
Language: _____

AFFIDAVIT OF PERSON OBTAINING ASSENT: I certify that I have explained to the above individual(s) the nature and purpose of the study, potential benefits, and possible risks associated with participation in this study. I have answered any questions that have been raised.

Printed Name of Individual Obtaining Assent: _____

Title: _____ Signature: _____ Date: _____

APPENDIX G**MAJOR THEMES – HOME, SCHOOL, AND SELF**

Table 1

Major Themes

Context	Major Themes		
	Bullying/ Teasing	Isolation	Psychosocial: Depression, etc.
Home Environment	<p>Bullied/yelled at by parent/sibling/relative</p> <p>Molestation</p> <p>My parents always look at me disapprovingly</p> <p>Lack of parental positive regard.</p> <p>No judgment at home by family, only outsiders.</p> <p>Told not to eat snacks, soda, but they buy it and never stop me</p> <p>My(younger) brothers tease me – “You’re not like us”.</p> <p>I call them names back-yellow teeth, big head (retaliation)</p> <p>I’m judged by my appearance.</p> <p>Mom says she gets looks about my weight.</p> <p>Verbal abuse from</p>	<p>I eat alone in the living room.</p> <p>I only exercise in our exercise room when no one else is there.</p> <p>Stress (when eating out)</p> <p>My Dad doesn’t want me to visit</p> <p>My mom doesn’t understand me.</p> <p>I would like to spend more time with my Mom.</p> <p>Wish I had someone to talk to.</p> <p>Only child</p> <p>Feel alone all the time</p> <p>Feel lonely</p>	<p>Annoyed, Irritated, Angry, Uncomfortable, Afraid, Tired, Pressure, Anxious, Embarrassment, frightened</p> <p>All day I want to go home.</p> <p>I like school, just not the people</p> <p>I’m smart.</p> <p>I don’t feel anything</p> <p>I like my size</p> <p>I never think about it</p> <p>I get mad for a moment during teasing</p> <p>I don’t think I’m big.</p> <p>Don’t see a problem.</p> <p>I eat Popeye’s but not the skin</p> <p>I get an attitude</p> <p>I’m cute, happy</p> <p>I don’t like my stepmother.</p> <p>I don’t like commotion</p> <p>.</p>

	<p>Mom about what others say.</p> <p>Mom says mean things -“You show up when food comes out.” “Slow down” (eating). “Your pants are too tight”</p> <p>Mom gets attitude with me.</p> <p>Chubby</p>	<p>No one understands</p> <p>I want to be left alone.</p> <p>I feel alone.</p> <p>I have nothing to do.</p> <p>I have to stop just sitting around.</p> <p>I can’t visit my incarcerated father</p> <p>All summer long all I do is watch TV and sleep.</p> <p>I cry as I walk home alone.</p> <p>I can’t go out in my neighborhood.</p> <p>I only go to and from school and back home.</p> <p>I don’t have time to make friends.</p> <p>Cornered</p> <p>Empty inside buy fat</p>	<p>Misunderstood</p> <p>Comfortable</p> <p>I have family support</p> <p>Stronger and happier at home- no judgment</p> <p>Confused going between worlds of home and school</p> <p>Comfortable at home</p> <p>Didn’t know I was fat</p> <p>Pressure from the outside</p> <p>Thought of stabbing myself but didn’t tell mom</p> <p>Sometimes I feel smart, other times, not.</p> <p>Stuck</p> <p>Argue with Mom often</p> <p>Sad girl</p> <p>Sitting “tight” in a knot</p> <p>Looks like I’m falling</p> <p>Don’t know what to do</p> <p>Tears and crying Help</p> <p>I’m happy but sad</p> <p>I cry to myself</p> <p>Broken on inside Heart broken</p>
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		<p>I need to stay in the house</p> <p>I can't look up to my Mom or anyone for support.</p> <p>Never feel whole</p> <p>Food and entertainment are my parents</p> <p>Feel empty after eating</p>	<p>I act happy, trying to be happy, really sad</p> <p>The drawing shows how I feel</p> <p>Sad about absent father</p> <p>Angry</p> <p>OK at home</p> <p>Sometimes horrible</p> <p>Self-anger</p> <p>No self-control</p> <p>Cornered and crowded at home</p> <p>Trapped</p> <p>Fear</p> <p>Nightmares</p> <p>Food comforts my emotions</p> <p>Addicted to food – sweets</p> <p>I see it, I eat it</p> <p>Don't want to be a food addict</p> <p>From anxiety to depression to sacrifice</p> <p>I must be anxious about feelings at home</p> <p>I am in pieces, at least colorful pieces</p> <p>Shapes holding each other</p>
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Context	Major Themes		
	Bullying/ Teasing	Isolation	Psychosocial: Depression, etc.
School	<p>Name calling- fat, stinky, big, lazy ugly, “blackie”, monkey.</p> <p>No one should be called these words. I can’t repeat what they call me/say to me.</p> <p>Teased about my hair – “baldheaded” but I have a weave now.</p> <p>Many people are bigger than me – more big ones than small ones.</p> <p>I’m medium at school compared to everyone else.</p> <p>They say my chest is real big – they’re jealous.</p> <p>Girls start fights because the boys like me and I’m smaller than them.</p> <p>I win fights.</p> <p>I fight at school all the time; I even fight boys.</p> <p>I starve myself at</p>		

	<p>school.</p> <p>Might get teased if I play basketball – most of the girls are skinny.</p> <p>Boyfriend says I’m fat “in a good way”</p> <p>I don’t get stares, they’re used to me, maybe I don’t notice. They think I don’t have feelings.</p> <p>Anxious around men at school.</p> <p>Teased about “special ed.”</p> <p>Teased about a particular body part: “big butt”, large breasts, and cheeks.</p> <p>Students are mean.</p> <p>My friend called me fat and ugly.</p> <p>People bring down my self-esteem and they don’t care.</p> <p>They think I don’t have feelings.</p> <p>It never ends.</p> <p>Laughing, pointing, staring/disgusted looks.</p> <p>I feel “watched” when eating.</p>		
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	<p>Everyone “Jonning” on me.</p> <p>You’re a nobody.</p> <p>The coach laughs when I’m not picked for teams.</p> <p>Pick on/hate on me.</p> <p>Say mean things.</p> <p>Judgmental, insensitive</p> <p>Safety issues because they jump out of nowhere. My mom stays on the phone with me when I’m walking home.</p> <p>I don’t care what people say because I’m always ready with a retort.</p> <p>It’s draining to spend all day telling people to stop staring, etc.</p> <p>People bother me.</p> <p>All day I want to go home.</p> <p>I feel like something is wrong with me when people stare.</p> <p>Even people who are bigger make fun.</p>		
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School Environment		<p>I don't see anyone. They don't have faces.</p> <p>I stay to myself and get good grades.</p> <p>I'd put a paper bag over my head.</p> <p>Don't like eating in public</p> <p>I walk to and from school alone</p> <p>I'm broken into pieces I have no friends.</p> <p>Being isolated at school is not a good feeling.</p> <p>Even when people are around, I am alone.</p> <p>I'm not one of them (peers)</p> <p>They get up and walk away like I stink.</p>	<p>Vulnerability</p> <p>Worried</p> <p>Deep emotional scars</p> <p>I feel sad</p> <p>I don't like school</p> <p>I don't like getting written up when others are rude</p> <p>Hiding</p> <p>I'm worried after dark</p> <p>Scared</p> <p>I feel weird and weirder</p> <p>Feel OK around people my size</p> <p>I need help</p> <p>I love school, it's easy</p> <p>Lots of friends</p> <p>My friends are all different sizes.</p> <p>I'm somewhat happy – half smile</p> <p>I'm not as tall as at home (art)</p> <p>I was happy about kickball, but I don't play any more</p> <p>Confident around friends.</p> <p>Happy, smiling</p>
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		<p>Last to get picked for teams</p> <p>Eat lunch away from cafeteria- they won't see me eat.</p> <p>Feel like a ghost – I'm not there and don't want to be there.</p> <p>Don't want to go to school</p>	<p>Confused, one day I appreciate my curves, next day I'm called fat</p> <p>Confident, excited about my looks.</p> <p>I get in trouble</p> <p>I have a cousin who is like a big sister</p> <p>At 10, I was sad and angry, wanted to die.</p> <p>Sad and angry at Mom</p> <p>Tried to stab myself</p> <p>I don't care</p> <p>I have anger issues</p> <p>Inconsistency</p> <p>I don't see anyone; they all look the same. They don't have faces.</p> <p>I'm smiling, happy mostly, but not at home.</p> <p>I know there are times I have depression.</p> <p>People think I'm different</p> <p>I have no social life at school</p> <p>Fear of criticism</p> <p>Low self esteem</p> <p>Bad feelings</p> <p>Sadness</p>
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			<p>Crying inside</p> <p>Depressed in the cafeteria</p> <p>I want to eat more</p> <p>I never talk about weight</p> <p>I'm losing a part of me that I can't love.</p> <p>I have to say that I'm beautiful.</p> <p>Concerned about looks</p> <p>Can't stand up for myself</p> <p>I feel fat</p>
Context Self	Major Themes		
	<p>Bullying/ Teasing</p> <p>People make fun of me.</p> <p>They laugh in my face.</p> <p>They don't see that I'm smart</p> <p>I'm funny to avoid being laughed at.</p> <p>I'm nude and people look in disgust. I felt normal until they were staring laughing, name calling.</p>	Isolation	<p>Psychosocial: Depression, Low self-esteem, etc.</p>

	<p>Teachers “call me out”</p> <p>If they keep staring, I’ll knock them out.</p> <p>People are looking, so I give them something to look at – my face.</p> <p>“You’re pretty, but fat”</p> <p>Stare at me for me, not because I’m fat.</p>		
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